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ABSTRACT

This annual report documents the National Drug Control Strategy's progress and plans for the future, and summarizes the implementation of the Nation's 10-year counter-drug strategy. The National Drug Control Strategy takes a long-term, holistic view of the nation's drug problem and recognizes the devastating effect drug abuse has on the nation's public health and safety. The Strategy maintains that no single solution can suffice to deal with this multifaceted challenge. The Strategy focuses on prevention; treatment; research; law enforcement; protection of our borders; drug supply reduction; and international cooperation. It provides general guidance while identifying specific initiatives. Chapter 1 of the report summarizes the National Drug Control Strategy. Chapter 2 provides information on drug use and availability and their social consequences. This information is based on the most recent national, state, and local surveys, among other studies. Given that these data instruments sometimes cover different time frames, consistent comparisons of data over the same period are not always possible. The Data Appendix summarizes the instruments used to prepare this Annual Report and outlines steps being taken to improve the information that supports national drug policy. Chapter 3 outlines accomplishments of (and modifications to) prevention; treatment; law enforcement; interdiction; and international programs (including private-sector and governmental initiatives and cooperative efforts). Chapter 4 reviews the Administration's fiscal year 2001 drug control budget proposal. Chapter 5 summarizes the consultation process followed by the Office of National Drug Control Policy during 1999 in implementing the National Drug Control Strategy. (GCP)

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ED 449 406

National Drug Control Strategy

2000 Annual Report

Office of National Drug Control Policy

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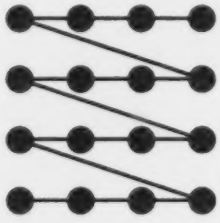
✳ COMMUNICATION.

THE ANTI-DRUG.

A positive relationship cannot exist without communication. Research shows that kids believe they have valuable things to say. When mentors ask them and listen genuinely, **it helps build self-esteem and confidence.** Also it demonstrates that you support their burgeoning independence as well as their ability to make intelligent decisions. The important thing to remember about drugs is that **it's not a five minute talk about sex. It's a dialogue.** As kids grow, they will need more information relevant to their exposure. In general, smoking marijuana is harmful. The younger a kid is, the more it may be. Research shows that people who smoke it before age 15 **are 7 times more likely to use other drugs.** It also shows that people who didn't smoke marijuana by age 21 were more likely to never smoke it. For more information, visit www.theantidrug.com or call 800.788.2800.



Communication is connection. During their teenage years, kids are exposed to an ever widening variety of people and influences. Know their friends as well as their friends' parents. Know your kids' routines and set curfews. Tell your kids that you care about them. Praise them when they do well, no matter how small the accomplishment. Stay connected.

Getting to know kids and staying involved with them is one of the most effective drug deterrents. Through their teenage years, this is not always easy. Even still, research shows that kids still want this to happen, even as they are exploring and growing into their own individuality. One way to do this is to set dates to do things together and plan routine activities (Saturday lunches, Sunday afternoon drives) where you can catch up. This message is brought to you by the Office of National Drug Control Policy/Partnership for a Drug-Free America®.

The National Drug Control Strategy: 2000 Annual Report

The President's Message

TO THE CONGRESS OF THE UNITED STATES:

On behalf of the American people, I am pleased to submit to Congress the 2000 Annual Report of the *National Drug Control Strategy*. This report documents our progress, details our plans for the future, and summarizes our implementation of the Nation's 10-year counter-drug strategy.

I am grateful to the Congress for the bipartisan partnership we have forged on this difficult and important issue. Common commitment has been vital to our success, and we can all be proud of our achievements at home and abroad. The 1998 National Household Survey on Drug Abuse found that youth drug use declined 13 percent between 1997 and 1998. The 1999 Partnership Attitude Tracking Survey and 1999 Monitoring the Future Survey tell us that youth attitudes about drugs are changing. Adolescents increasingly disapprove of illegal drugs. An ever-growing number of young people are now using positive peer pressure to help friends stay drug-free. Our children get the message: "In America today you have a bright, drug-free future. Don't waste it with drugs."

We have made similar progress combating illegal drug organizations that traffic in these deadly poisons. We have cut drug-related murders to their lowest point in over a decade. We are reducing the supply of drugs on world markets. In Latin America, Bolivia reduced coca cultivation by 55 percent since 1995 and in Peru cultivation declined 66 percent over the same period. Bipartisan efforts to confront this threat are paying real dividends to the American people.

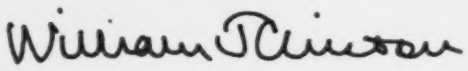
But we cannot rest on our success. Drugs continue to exact a tremendous toll on this country and internationally. Studies report an increase in steroid and MDMA (ecstasy) use among youth. One in four inmates in State prison and more than 60 percent of Federal inmates are drug offenders. Cocaine and heroin production have skyrocketed in Colombia.

The 2000 Annual Report illustrates where we need to focus our energies and the initiatives needed to address the most pressing problems:

- We need to empower America's young people to reject illegal drugs.
- We need to break the cycle of drugs and crime by dramatically increasing drug treatment programs within the criminal justice system. These programs have been proven to reduce drug use and cut recidivism by up to 44 percent.
- We need to close the gap between the number of people who have serious drug abuse problems and the treatment slots available on demand. If drug-dependent individuals want to become drug-free, they deserve our help.
- We must strengthen efforts to stop the flow of drugs into the United States across our southwest border and other points of entry. Through new technologies and better coordination, we can speed up the flow of legitimate goods and services while turning off the tap for drugs.
- We must help committed democracies resist the transnational threat posed by illegal drugs and the criminal organizations that traffic in them.

These vital initiatives are key elements in our broad-based, balanced approach to combating drug abuse.

Working together, the Congress and the Administration, teachers, coaches, clergy, researchers, mentors, health-care professionals, community activists, and others have made great progress in reducing drug abuse. By doing so, we have safeguarded the dreams of our children. We have increased the sense of security American families feel in their homes, streets, and communities. We have helped the international community combat a threat that respects no borders. We have much to be proud of, but we have much more to do. I look forward to working closely with the Congress in this effort.



The White House

Foreword

This report provides information on progress over the past year in implementing the *National Drug Control Strategy*. It details trends in drug use and availability; assesses the costs of drug abuse to our society; and outlines accomplishments of federal prevention, treatment, law enforcement, interdiction, and international programs.

We remain committed to the *Strategy* that focuses on shrinking America's demand for drugs, through prevention and treatment, and attacking the supply of drugs through law enforcement and international cooperation.

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem later in life. To this end, the Strategy seeks to involve parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign.

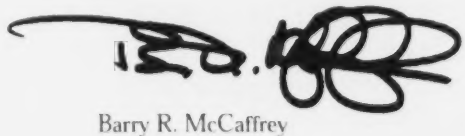
Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment can help them end dependence on addictive drugs. Treatment programs also reduce the consequences of addiction on the rest of society. Providing treatment for America's chronic drug users is both compassionate public policy and a sound investment.

Along with prevention and treatment, law enforcement is essential for reducing drug use in the United States. Illegal drug trafficking inflicts violence and corruption on our communities. Law enforcement is the first line of defense against such unacceptable activity.

The federal government alone bears responsibility for securing our national borders. Better organization along land borders and at air and seaports will reduce the volume of illegal drugs reaching American communities.

The rule of law and human rights are both threatened by drug trafficking. Supply-reduction programs attack international criminal organizations, strengthen democratic institutions, and honor our drug-control commitments abroad.

We are confident that a balanced strategy that relies on prevention, treatment, law enforcement, supply reduction, and international coordination can dramatically reduce the prevalence and social consequences of drug abuse.



Barry R. McCaffrey
Director
Office of National Drug Control Policy

The National Drug Control Strategy: 2000 Annual Report

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I. Annual Report and the *National Drug Control Strategy:* An Overview

Annual Report on Implementing the *National Drug Control Strategy*

Prior to this year, Congress required the Administration to submit a *National Drug Control Strategy* each year. The most recent strategy was submitted in February 1999. Public Law 105-277 now requires the President to submit to Congress only an annual report on the progress in implementing the *Strategy*.* General reporting requirements for the Annual Report include:

1. Assessment of federal success in achieving the *National Drug Control Strategy* goals and objectives (using the *Strategy's* Performance Measures of Effectiveness system). This analysis includes an assessment of drug use and availability in the United States as well as prevention, treatment, law enforcement, interdiction, and international programs.
2. Modifications during the preceding year of the *National Drug Control Strategy* or national drug control performance measurement system.
3. Explanation of how the Administration's budget proposal is intended to implement the *National Drug Control Strategy*.
4. Measurable data from the annual performance measures.
5. An assessment of private-sector initiatives and cooperative efforts dealing with drug control among federal, state, and local governments.

This annual report addresses the specific reporting requirements outlined in PL 105-277.

- **Chapter 1** summarizes the *National Drug Control Strategy*.
- **Chapter 2** provides information on drug use and availability and their social consequences. This information is based on the most recent national, state, and local surveys, among other studies. Given that these data instruments sometimes cover different time frames, consistent comparisons of data over the same period are not always possible. The *National Household Survey on Drug Abuse* (released in August 1999), for example, provides information about drug use in 1998 while the *Monitoring the Future Survey* (released in December 1999) contains 1999 data. The *Data Appendix* summarizes the instruments used to prepare this *Annual Report* and outlines steps being taken to improve the information that supports national drug policy.
- **Chapter 3** outlines accomplishments of (and modifications to) prevention, treatment, law enforcement, interdiction, and international programs (including private-sector and governmental initiatives and cooperative efforts).
- **Chapter 4** reviews the Administration's Fiscal Year 2001 drug control budget proposal. More details about the budget proposal are provided in the companion *Budget Summary* volume.
- **Chapter 5** summarizes the consultation process followed by the Office of National Drug Control Policy during 1999 in implementing the *National Drug Control Strategy*.
- **The second companion volume** — *Performance Measures of Effectiveness 2000* — provides information on ninety-seven specific performance targets used to gauge progress in the *Strategy's* five goals and thirty-one

* A revised *National Drug Control Strategy* may, however, be submitted at any time upon a determination by the President, in consultation with the ONDCP Director, that the *National Drug Control Strategy* is not sufficiently effective or when a new President or ONDCP Director takes office.

objectives. The 2000 PME report assesses progress against the base year of 1996 and outlines mid- (2002) and long-term (2007) goals. The report also outlines modifications made in the national drug control performance measurement system.

- **A third companion volume** - *Counterdrug Research and Development Blueprint Update* - reviews the research agenda of ONDCP's Counter-Drug Technology Assessment Center and contains the Annual Report on Development and Deployment of Narcotics Detection Technology required by 21USC/505a.
- **The *National Drug Control Strategy*** also includes a separate *Classified Annex*, which is transmitted to Congress separately. This document is the President's interagency plan for countering international drug cultivation, production, and trafficking.

The National Response to Drug-Abuse

The American people have always demonstrated a resolve to fortify the nation's democratic structures and improve opportunities for all citizens. In the face of divergent threats, successive generations were determined to build a stronger, healthier country. These essential values remain with us today, especially in connection with the problem of substance abuse. The vast majority of Americans repeatedly assert a desire to be rid of illegal drugs. The United States is committed to reducing drug use and its destructive consequences.

Drug abuse and related crime permeate every corner of our society, afflicting inner cities, affluent suburbs, and rural communities. Drugs affect rich and poor, educated and uneducated, professionals and blue-collar workers, young and old. Seventy-three percent of drug users in America are employed. Some of the elderly suffer from addiction as do people in the prime of their lives. Drug use is prevalent among the young although it is not as widespread as many children and adolescents think.

The history of drug use in America indicates this blight is cyclic in nature. When the nation fails to pay attention and take precautions, drug abuse spreads. The introduction of cocaine in the late nineteenth century exemplifies how attitudes affect the incidence of drug abuse. Cocaine use skyrocketed because the psycho-pharmacological effects of this drug were poorly understood while its alleged benefits were touted by health authorities whose claims were repeated in commercial advertising. Only when the negative consequences of cocaine addiction became widespread did perceptions change. Drug abuse was condemned and new laws were passed, creating a healthier nation with a lower crime rate.

When people no longer focused on the problem of drug abuse, it resurfaced. New drugs were developed, some of which were more potent than their predecessors. Associated with these drugs were subcultures with special appeal for the young and impressionable. Once again, drug abuse increased as did its deleterious consequences. Twice in this century drug use rose and then fell. Illegal drugs never disappeared entirely although the percentage of Americans who used them declined dramatically.

If we aren't careful, the numbers of drug abusers could go up again. Drug use among children is a particularly urgent concern. Beginning around 1990, teens and preteens adopted more permissive attitudes toward drugs. Soon thereafter, actions followed perceptions, and use of illegal drugs increased among young people. This trend continued through 1996 before stabilizing in 1997. In 1998, 6.2 percent of Americans twelve and older were current users of illicit drugs. This figure is down 56 percent from the 14.1 percent of the U.S. population twelve and older who were current users in 1979.

Drug abuse and its consequences can be reduced. By historical standards, present rates of drug use are relatively low. With the concerted efforts outlined in the *National Drug Control Strategy* and described in this *Annual Report*, we can lower them further. Indeed, the will of the American people is such that we aim to slash rates of drug use by half over the next several years.

The Role of Government

The first duty of government is to provide security for citizens. The Constitution of the United States articulates the obligation of the federal government to uphold the public good, providing a bulwark against all threats, foreign and domestic. Drug abuse, and the illicit use of alcohol and tobacco by those under the legal age, constitute such a threat. Toxic, addictive substances are a hazard to our safety and freedom, producing devastating crime and health problems. Drug abuse diminishes the potential of citizens for growth and development. However, the federal government cannot address the problem alone. Drug abuse demands a comprehensive solution involving not only federal programs but also efforts on the part of

states, counties, cities, communities, families, civic groups, coalitions, and other organizations.

The rule of law and individual freedom are not incompatible. Although government must minimize interference in the private lives of citizens, it cannot deny people the security on which peace of mind depends. Drug abuse impairs rational thinking and the potential for a full, productive life. Drug abuse, drug trafficking, and their consequences destroy personal liberty and the well-being of communities. Drugs drain the physical, intellectual, spiritual, and moral strength of America. Crime, violence, workplace accidents, family misery, drug-exposed children, and addiction are only part of the price imposed on society. Illegal drugs indiscriminately destroy old and young, men and women, from all racial and ethnic groups and every walk of life.

Mandate for a *National Drug Control Strategy*

The federal government has responded to drug abuse and trafficking with the following laws and executive orders:

- **The Controlled Substances Act, Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970** provides an effective approach to the regulation, manufacture, and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the production of controlled substances.
- **The Comprehensive Crime Control Act of 1984** and other statutes passed by the 98th Congress reformed the bail and sentencing laws applicable to drug trafficking and other crimes, created a new offense with an enhanced penalty for distributing drugs near schools, and revised civil and criminal forfeiture laws.
- **The Anti-Drug Abuse Act of 1986** enhanced penalties for drug trafficking. It also created a new offense with an enhanced penalty for using a juvenile to commit a drug offense, amended the forfeiture laws, proscribed trafficking in controlled substance "analogues" (sometimes referred to as "designer" drug), created money laundering offenses, and proscribed use of interstate commerce to distribute drug paraphernalia.
- **Executive Order No. 12564 (1986)** makes refraining from illegal drug use a condition of employment for all federal employees. This order requires every federal agency to develop a comprehensive drug-free workplace program.
- **The Anti-Drug Abuse Act of 1988** establishes as a policy goal the creation of a drug free America. A key provision of the Act is the establishment of the Office of National Drug Control Policy (ONDCP) to set priorities, implement a national strategy, and certify federal drug control budgets. The law specifies that the strategy must be comprehensive and research-based; contain long-range goals and measurable objectives; and seek to reduce drug abuse, trafficking, and their consequences. Specifically, drug abuse is to be curbed by preventing youth from using illegal drugs, reducing the number of users, and decreasing drug availability.
- **The Violent Crime Control and Law Enforcement Act of 1994** extends ONDCP's mission to assessing budgets and resources related to the *National Drug Control Strategy*. It also establishes specific reporting requirements in the areas of drug use, availability, consequences, and treatment.
- **Executive Order No. 12880 (1993) and Executive Orders Nos. 12992 and 13023 (1996)** assign ONDCP responsibility within the executive branch of government for leading drug control policy and developing an outcome-measurement system. The executive orders also charter the President's Drug Policy Council and establish the ONDCP Director as the President's chief spokesman for drug control.
- **The Office of National Drug Control Policy Reauthorization Act of 1998** expands ONDCP's mandate and authority. It sets forth additional reporting requirements and expectations, including:

  1) Development of a long-term national drug strategy
  2) Implementation of a robust performance-measurement system
  3) Commitment to a five-year national drug control program budget
  4) Permanent authority granted to the High Intensity Drug Trafficking Areas (HIDTA) program along with improvements in HIDTA management
  5) Greater demand-reduction responsibilities given to the Counter-Drug Technology Assessment Center (CTAC)
  6) Statutory authority for the President's Council on Counter-Narcotics
  7) Increased reporting to Congress on drug control activities
  8) Reorganization of ONDCP to allow more effective national leadership

9) Improved coordination among national drug control program agencies

10) Establishment of a Parents Advisory Council on Drug Abuse

Evolution of the *National Drug Control Strategy*

National drug control strategies were produced annually between 1989 and 1999. The strategies increasingly recognized the importance of preventing drug use by young people. The various documents affirmed that no single approach could rescue the nation from the cycle of drug abuse. A consensus was reached that drug prevention, education, treatment, and research must be complemented by supply-reduction abroad, on our borders, and within the United States. Each strategy shared the commitment to maintain and enforce anti-drug laws. All the strategies, with growing success, tied policy to a scientific body of knowledge about the nation's drug problems. The *1996 Strategy* established five goals and thirty-two supporting objectives as the basis for a coherent, long-term national effort. These goals remain the heart of the *1999 Strategy* and will guide federal drug control agencies over the next five years. These goals are useful for state and local governments as well as the private sector.

Overview of the *National Drug Control Strategy*

The *National Drug Control Strategy* takes a long-term, holistic view of the nation's drug problem and recognizes the devastating effect drug abuse has on the nation's public health and safety. The *Strategy* maintains that no single solution can suffice to deal with this multifaceted challenge. The *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, drug supply reduction, and international cooperation. It provides general guidance while identifying specific initiatives. Through a balanced array of demand-reduction and supply-reduction actions, we strive to achieve a 50 percent decrease in drug use and availability and at least a 25 percent decrease in the consequences of drug abuse by 2007. If this goal is achieved, just 3 percent of the household population aged twelve and over would use illegal drugs. This level would be the lowest documented drug-use rate in American history. Drug-related health, economic, social, and criminal costs would be reduced commensurately.

Preventing drug use in the first place is preferable to addressing the problem later through law enforcement and treatment. The *Strategy* focuses on young people, seeking to educate them about the dangers of illegal drugs, alcohol, and tobacco. In addition to drug-prevention for children, intervention programs must help young adults as they leave home to start college or join the workplace.

There are approximately five million drug abusers who need immediate treatment, and who constitute a major portion of domestic demand. Without help, these adults will suffer from poor health, unstable family relations, and other negative consequences of substance abuse. Since parental alcohol and drug abuse is a significant predictor of youth drug use and is often the cause of serious child abuse and neglect, treatment for parents is key to breaking the inter-generational cycle of addiction. Accordingly, the *Strategy* focuses on treatment. Research clearly demonstrates that treatment works. We must take advantage of all opportunities - in the workplace, the criminal justice system, and our communities - to encourage drug abusers to become drug-free.

Substance abuse by offenders is another area of concern. In 1997, a third of state prisoners and about one in five federal prisoners said they had committed the offenses that led to incarceration while under the influence of drugs. A zero-tolerance drug program that includes treatment for substance abuse, in lieu of incarceration, will help large numbers of non-violent, drug related offenders. Experience proves that drug courts, drug testing, and drug treatment within the criminal justice system can reduce drug consumption and recidivism. Over time, expanded alternatives to incarceration promise to decrease the addicted population and reduce both crime and the number of incarcerated Americans. The ultimate goal is to help people with drug problems renounce crime and enter the workforce as productive, self-sufficient, tax-paying members of society. Education and job-training should accompany treatment.

Effective law enforcement is essential in reducing drug-related crime within the United States. Illegal drug trafficking inflicts violence and corruption on our communities. The criminal activity that comes with drug trafficking has both a domestic and international component. Domestic traffickers are often linked with international organizations. Federal, state, and local law

enforcement organizations, working together through programs like the Organized Crime Drug Enforcement Task Force (OCDETF) and High Intensity Drug Trafficking Area (HIDTA), must share information and resources in order to maximize their impact on criminal drug trafficking organizations.

The *Strategy* stresses the need to protect borders from drug incursion and cut drug supply more effectively in domestic communities. It emphasizes initiatives to share intelligence and make use of the latest technology in these efforts. As a major gateway for the entry of illegal drugs into the United States, the Southwest border receives considerable attention within the *Strategy*. Resources have also been allocated to close other avenues of drug entry into the United States, including the Virgin Islands, Puerto Rico, the Canadian border, and all air and sea ports.

The United States seeks to curtail illegal drug trafficking in the transit zone between source countries and the U.S. Multinational efforts in the Caribbean, Central America, Europe, and the Far East are being coordinated to exert maximum pressure on drug traffickers. The United States supports a number of international efforts against drug trafficking that are being coordinated with the United Nations (UN), the European Union (EU), and the Organization of American States (OAS).

Supply-reduction operations can best be mounted at the source: the Andean Ridge for cocaine and heroin; Mexico for methamphetamine, heroin, and marijuana; and Southeast Asia and South Central Asia for heroin. Where access to source regions is limited by political complications, we support international efforts to curtail the drug trade.

The *National Drug Control Strategy* is based on sound research, technology, and intelligence. The *Strategy* will be adjusted according to feedback from ONDCP's Performance Measures of Effectiveness system. Conditions are fluid, so the *Strategy* will change to respond to emerging issues. We can measure - target by target - how successful we are in achieving goals and objectives. The *Strategy* receives input from a wide range of organizations, individuals, and government branches.

The overriding objective of our drug control strategy is to keep Americans safe from the threats posed by illegal drugs. We hope to create a healthier, less violent, stable nation unfettered by drug traffickers and the corruption they perpetrate.

Goals of the *National Drug Control Strategy**

Goal 1: Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.

Drug use is preventable. If children reach adulthood without using illegal drugs, alcohol, or tobacco, they are unlikely to develop a chemical-dependency problem. To this end, the *Strategy* fosters initiatives to educate children about the dangers associated with drugs. ONDCP involves parents, coaches, mentors, teachers, clergy, and other role models in a broad prevention campaign. ONDCP encourages businesses, communities, schools, the entertainment industry, universities, and sports organizations to join these national anti-drug efforts.

Researchers have identified important factors that place youth at risk for drug abuse or protect them against such behavior. Risk factors are associated with greater potential for drug problems while protective factors reduce the chances of drug problems. Risk factors include a chaotic home environment, ineffective parenting, anti-social behavior, drug-using peers, general approval of drug use, and the misperception that the overwhelming majority of one's peers are substance users. Protective factors include parental involvement; success in school; strong bonds with family, school, and religious organizations; knowledge of dangers posed by drug use; and the recognition by young people that substance use is not acceptable behavior.

Goal 2: Increase the safety of America's citizens by substantially reducing drug-related crime and violence.

The negative social consequences of drug-related crime and violence mirror the tragedy that substance abuse wreaks on individuals. A large percentage of the twelve million property crimes committed each year in America are drug related, as is a significant proportion of nearly two million violent crimes. The approximately five million drug abusers in need of treatment contribute disproportionately to this problem.

Increasing public safety is accomplished through a number of initiatives. Drug-related crime can be reduced through community-oriented policing and other law-enforcement tactics, which have been demonstrated by

* The goals and objectives are listed in an insert to this annual report.

police departments in New York and other cities where crime rates are plunging. Cooperation among federal, state, and local law-enforcement agencies also makes a difference. So, too, do operations targeting gangs, trafficking organizations, and violent drug dealers. Equitable enforcement of fair laws is critical. We are a nation wedded to the prospect of equal justice for all. Punishment must be perceived as commensurate with the offense. Finally, the criminal justice system must do more than punish. It should use its coercive powers to break the cycle of drugs and crime. Substance abuse treatment should be made available in our nation's prisons.

Goal 3: Reduce health and social costs to the public of illegal drug use.

Drug dependence is a chronic, relapsing disorder that exacts an enormous cost on individuals, families, businesses, communities, and nations. Addicted individuals frequently engage in self-destructive and criminal behavior. Treatment programs can reduce the consequences of addiction on the rest of society. The ultimate goal of treatment is to enable a patient to become abstinent and to improve functioning through sustained recovery. On the way to that goal, reduction of drug use, improvement of the addict's ability to function in society, and addressing the medical needs of the addicted are useful interim outcomes. Providing treatment for America's chronic drug abusers is both compassionate public policy and a sound investment.

Goal 4: Shield America's air, land, and sea frontiers from the drug threat.

The United States is obligated to protect its citizens from the threats posed by illegal drugs crossing our borders. Interdiction in the transit and arrival zones disrupts drug flow, increases risks to traffickers, drives them to less efficient routes and methods, and prevents significant quantities of drugs from reaching the United States. Interdiction operations also produce information that can be used by domestic law-enforcement agencies against trafficking organizations.

Goal 5: Break foreign and domestic drug sources of supply.

The rule of law, human rights, and democratic institutions are threatened by drug trafficking and consumption. International supply-reduction programs not only reduce the volume of illegal drugs reaching our shores, they also attack international criminal organizations, strengthen democratic institutions, and honor our international drug control commitments. The U.S. supply-reduction strategy seeks to: (1) eliminate illegal drug cultivation and production, (2) destroy drug trafficking organizations, (3) interdict drug shipments, (4) encourage international cooperation, and (5) safeguard democracy and human rights. Additional information about international drug control programs is contained in the *Classified Annex* to this *Strategy*.

The United States continues to focus international drug control efforts on source countries. International drug-trafficking organizations and their production and trafficking infrastructures are most concentrated, detectable, and vulnerable to effective law-enforcement action in source countries. In addition, cultivation of coca and opium poppy and production of cocaine and heroin are labor intensive. For these reasons, cultivation and processing are relatively easier to disrupt than other aspects of the trade. The international drug control strategy seeks to bolster source-country resources, capabilities, and political will to reduce cultivation, attack production, interdict drug shipments, and disrupt and dismantle trafficking organizations, including their command and control structure and financial underpinnings.

Drug Control Is a Continuous Challenge

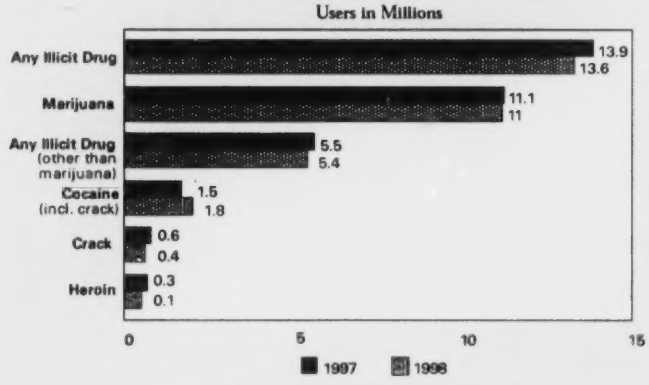
The metaphor of a "war on drugs" is misleading. Although wars are expected to end, drug education – like all schooling – is a continuous process. The moment we believe ourselves victorious and drop our guard, drug abuse will resurface in the next generation. To reduce the demand for drugs, prevention must be ongoing. Addicted individuals should be held accountable for their actions and offered treatment to help change destructive behavior.

Cancer is a more appropriate metaphor for the nation's drug problem. Dealing with cancer is a long-term proposition. It requires the mobilization of support mechanisms – medical, educational, social, and financial – to check the spread of the disease and improve the patient's prognosis. Symptoms of the illness must be managed while the root cause is attacked. The key to reducing the incidence of drug abuse and cancer is prevention coupled with treatment and accompanied by research.

II. America's Drug Use Profile

An estimated 13.6 million Americans twelve years of age and older were current users of any illegal drug in 1998.* This number is slightly less than the 13.9 million estimate for 1997. Drug use reached peak levels in 1979 when 25.4 million percent of the population age twelve and over were current users. This figure declined significantly between 1985 and 1992, from 23.3 million to twelve million. Current use rates increased from twelve million in 1992 to thirteen million in 1996. Since 1996, the number of current users remained steady, with statistically insignificant changes occurring each year. An estimated 5 million people met diagnostic criteria for dependence on illegal drugs in 1997 and 1998, including 1.1 million youths between the ages of twelve and seventeen.[1]

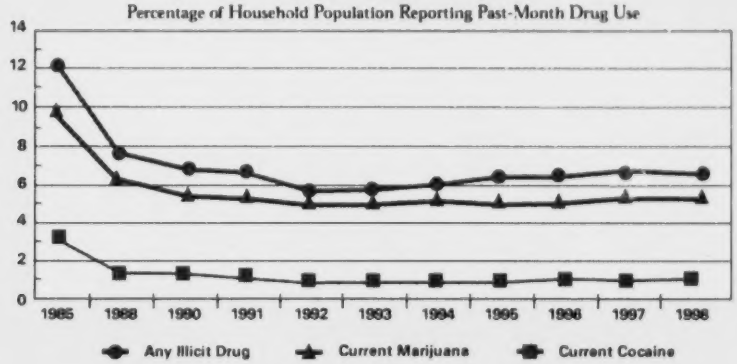
In 1998, There Were 13.6 Million Current (Past-Month) Users of Illicit Drugs



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Drug use affects all Americans. More than half of our citizens (53 percent) say their concern about drug use has increased over the past five years; alarm is growing most in minority and low-income communities.[2] In 1999, a study by the National League of Cities cited use of illegal drugs, alcohol, and tobacco among youth as one of the top threats to America in the new millennium.[3] Even citizens who do not come into contact with illegal drug users share the burden of drug abuse. All of us pay the toll in the form of higher health-care costs, dangerous neighborhoods, and an overcrowded criminal justice system.

Current Drug-Use Rates



Source: SAMHSA, National Household Survey on Drug Abuse (various years)

* The term "drug" is defined in the Office of National Drug Control Policy Reauthorization (21 USC 1701) as: "the meaning given the term 'controlled substance' in section 102(6) of the Controlled Substances Act (21 USC 802(6))." Current use is defined as consumption of a controlled substance at least once within the previous thirty days.

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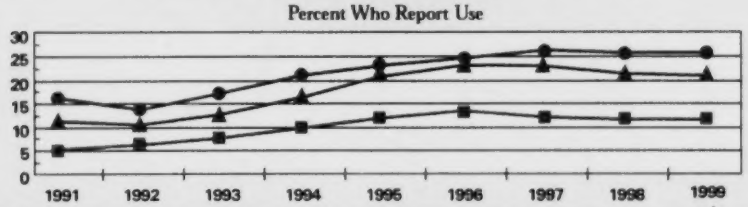
Youth Trends in Current (Past-Month) Use of Any Illicit Drug



	1991	1992	1993	1994	1995	1996	1997	1998	1999
12th Grade	16.4	14.4	18.3	21.9	23.8	24.6	26.2	25.6	25.9
10th Grade	11.6	11.0	14.0	18.5	20.2	23.2	23.0	21.5	22.1
8th Grade	5.7	6.8	8.4	10.9	12.4	14.6	12.9	12.1	12.2

Source: 1999 Monitoring the Future Study

YOUTH DRUG USE TRENDS

Young Americans are especially vulnerable to drug abuse. Their immature physical and psychological development makes them highly susceptible to the ill effects of drugs for years to come. Moreover, behavior patterns that result from teen and preteen drug use often produce tragic consequences. Self-degradation, loss of control, disruptive conduct, and antisocial attitudes can cause untold harm to themselves and their families.

Juvenile drug-use rates level off — According to the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration's (SAMHSA) 1998 National Household Survey on Drug Abuse (NHSDA), 9.9 percent of youth age twelve to seventeen reported current use of an illegal drug in 1998 – a 13 percent decrease from 11.4 percent in 1997. This decline was the first statistically significant drop in four years.[4] For the age group between eighteen to twenty-five years of age, current use of any illegal drug has been rising since 1994 and currently stands at 16.1 percent. This increase reflects the maturing of youth who experienced greater drug-use rates between 1992 and 1996. General changes in drug use are often linked to marijuana – the most frequently used illegal drug.[5] According to the 1999 Monitoring the Future survey (MTF), lifetime and past-year use of all illegal drugs did not change from 1998 to 1999 for eighth, tenth, and twelfth graders.

Marijuana use linked to crime and antisocial behavior — Marijuana use by young people has been associated with a wide range of dangerous behavior. Children who begin smoking "pot" at an early age are less likely to finish school and more apt to engage in acts of theft, violence, vandalism, and other high-risk behavior than children who do not smoke marijuana.[6] In 1996, nearly one million adolescents, age sixteen to eighteen, reported at least one incident of driving within two hours of using an illegal drug (most often marijuana) in the past year.[7] An analysis of Maryland juvenile detainees found that 40 percent were in need of substance-abuse treatment. Among this group, 91 percent needed treatment for marijuana dependence.[8] The link between early marijuana use and long-term substance abuse is demonstrated by "an almost four-fold increase in the likelihood of problems with cigarettes and a more than doubling of the odds of alcohol and marijuana problems."[9]

Changing teen attitudes — The Partnership for a Drug-Free America's 1999 Partnership Attitude Tracking Study (PATS) indicates that disapproval of drugs among 7th through 12th graders reflected their knowledge of drug-related risks. The study reported that the percentage of respondents strongly agreeing with the statement: "kids who are really cool don't use drugs" increased from 35 percent in 1998 to 40 percent in 1999. The teenage belief that "most people will try marijuana sometime" has declined to 35 percent, from 40 percent in 1998 and 41 percent in 1997. In addition, 68 percent of teens believed that a person who uses marijuana runs a higher risk of getting into trouble with the law – up from 64 percent in 1998.[10] The 1999 MTF data support this trend: disapproval of trying marijuana increased among eighth graders, from 69 percent in 1998 to 70.7 percent in 1999. Likewise, disapproval of regular inhalant use increased among tenth graders, rising from 91.1 percent in 1998 to 92.4 percent in 1999.[11]

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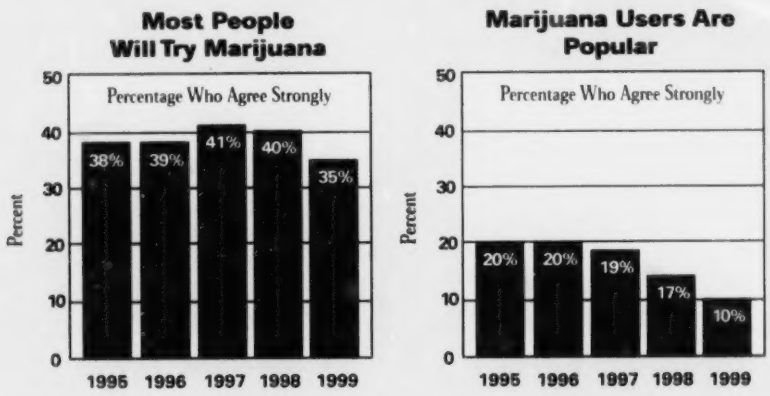
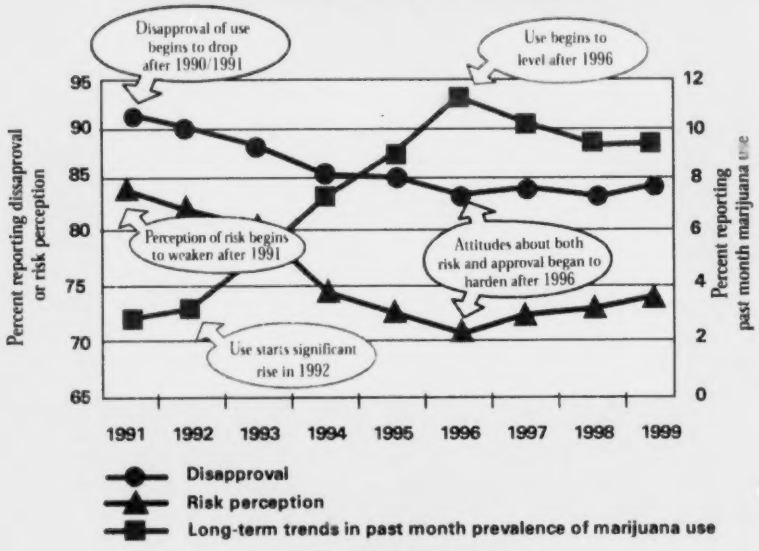
Student Perceptions of Marijuana are Changing



Source: 1999 Partnership for a Drug Free America Tracking Study

Youth Attitudes Determine Behavior

The case of 8th Graders and Marijuana



Source: 1999 Monitoring the Future Study

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Emerging drug-use trends among youth — The 1999 MTF survey reports increasing use of 3,4-methylenedioxymethamphetamine (MDMA) and steroids among students in eighth, tenth, and twelfth grades. Past-year use of steroids among both eighth and tenth graders increased from 1.2 percent in 1998 to 1.7 percent in 1999. Between 1998 and 1999 past-year use of MDMA (also called ecstasy) among twelfth graders increased from 3.6 percent to 5.6 percent, respectively. In addition, past-year use of MDMA among tenth graders increased from 3.3 percent to 4.4 percent.

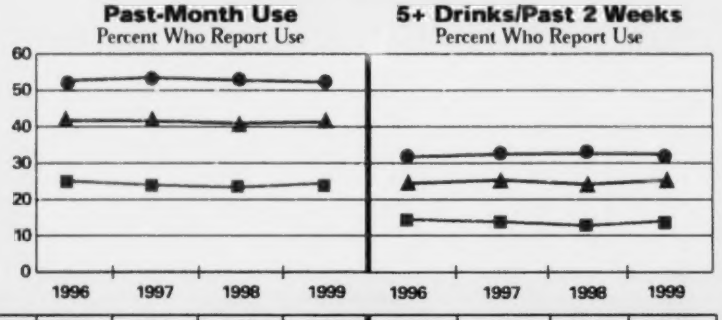
Underage use of alcohol — Young people use alcohol more than illegal drugs. The younger a person is when alcohol use begins, the greater the risk of developing alcohol abuse or dependence problems later in life. Over 40 percent of youth who begin drinking before age fifteen become dependent on alcohol compared with just 10 percent of those who begin drinking at age twenty-one.[12] Alcohol use among the young strongly correlates with adult drug use. For example, adults who started drinking at early ages are nearly eight times more likely to use cocaine than adults who did not drink as children.[13]

The United States had 10.4 million underage current drinkers of alcohol in 1998 (compared to eleven million in 1997). In this group, 5.1 million engaged in binge drinking, and another 2.3 million were classified as heavy drinkers.[14] The 1999 MTF reports that daily alcohol use by twelfth graders declined 13 percent (from 3.9 percent to 3.4 percent) since 1998. The proportion of tenth graders reporting drunkenness sometime during the past year increased to 40.9 percent in 1999 - up from 38.3 percent in 1998. The number of eighth graders who were binge drinkers rose from 13.7 percent in 1998 to 15.2 in 1999. In 1999, past-month alcohol use for eighth graders in metropolitan areas was lower than for eighth graders in rural areas (21.7 percent versus 28.1 percent).[15]

Underage use of tobacco — The younger a person is when smoking begins, the greater the risk of contracting a disease attributable to smoking. The 1998 NHSDA estimates that every day more than three thousand people aged eighteen or younger try their first cigarette. If these trends continue, approximately five million individuals now under eighteen will die early from a preventable disease associated with smoking. Widely available and legal for those of required age, tobacco is one of the easiest illicit substances of abuse for children to obtain.

Smoking tobacco and use of illegal drugs appear to be linked. The 1998 NHSDA indicates that youths age twelve to seventeen who currently smoked cigarettes were 11.4 times more likely to use illegal drugs and sixteen times more likely to drink heavily than youths who did not smoke.[16] An estimated 18.2 percent (4.1 million) people in this age group were current cigarette smokers in 1998. This rate has remained relatively stable since 1988.[17] In 1997, 39.7 percent of white high school students currently smoked cigarettes, compared with 34 percent for Hispanics and 22.7 percent for African-Americans.[18] According to the 1999 National Youth Tobacco Survey, these numbers decreased to 32.8 percent, 25.8 percent, and 15.8 percent, respectively.[19] This survey

Youth and Alcohol



	1996	1997	1998	1999	1996	1997	1998	1999
12th Grade	50.8	52.7	52.0	51.0	30.2	31.3	31.5	30.8
10th Grade	40.4	40.1	38.8	40.0	24.8	25.1	24.3	25.6
8th Grade	26.2	24.5	23.0	24.0	15.6	14.5	13.7	15.2

Source: 1999 Monitoring the Future Study

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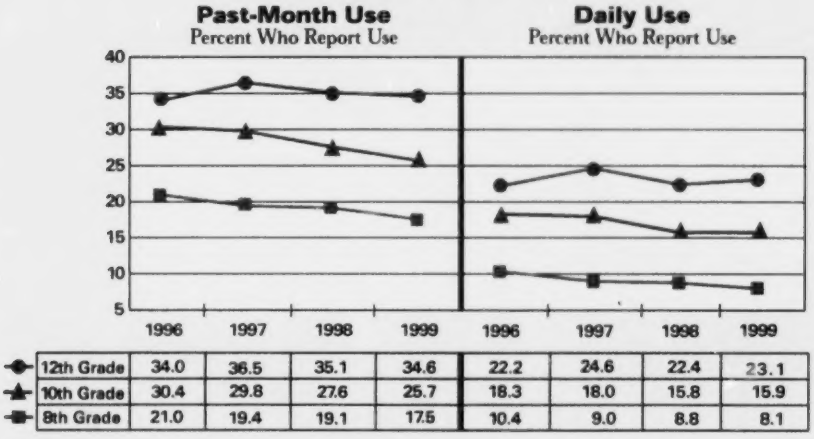
Youth and Cigarettes



	1996	1997	1998	1999	1996	1997	1998	1999
12th Grade	34.0	36.5	35.1	34.6	22.2	24.6	22.4	23.1
10th Grade	30.4	29.8	27.6	25.7	18.3	18.0	15.8	15.9
8th Grade	21.0	19.4	19.1	17.5	10.4	9.0	8.8	8.1

Source: 1999 Monitoring the Future Study

also reports that about one in ten (9.2 percent) middle school students and more than a quarter (28.4 percent) of high school students are current cigarette smokers; 12.8 percent of middle school students and 34.8 percent of high school students use *any* type of tobacco.[20] In rural America, eighth graders are twice as likely to have smoked cigarettes in the past month than their peers in large metropolitan areas (26.1 percent versus 12.7 percent) and almost five times more likely to have used smokeless tobacco (8.9 percent versus 1.8 percent).[21]

The recent entry of Indian "bidis"* into the American market poses a new tobacco related health problem, especially in relation to youth. This type of cigarette is available at gas stations, liquor stores, ethnic food shops, selected health stores, and through the Internet. Bidis must be puffed more frequently than regular cigarettes, and inhaling a bidi requires great pulmonary effort due to its shape and poor combustibility. Consequently, bidi smokers breathe in greater quantities of tar and other toxins than smokers of regular cigarettes.[22] In addition, bidis contain in excess of three times the amount of nicotine and five times the tar than regular cigarettes.[23] Bidi smokers have twice the risk of contracting lung cancer compared to people who smoke filtered cigarettes; five times the risk of suffering heart disease; and a considerably greater risk for cancer of the oral cavity, pharynx, larynx, lungs, esophagus, stomach, and liver.[24]

Drug abuse and sexual activity — Juvenile abuse of alcohol and other drugs is strongly associated with risk-taking behavior, including promiscuity. According to the 1999 National Center on Addiction and Substance Abuse (CASA) study "Dangerous Liaisons," increased promiscuity leads to a greater risk for sexually transmitted diseases and unplanned teenage pregnancy.[25] Adolescents aged fourteen and younger who use alcohol are twice as likely to engage in sexual behaviors than non-drinkers; drug users are five times more likely to be sexually active than youth who are drug-free. Teens between the age of fifteen and nineteen who drink are seven times more likely to have sex and twice as likely to have four or more partners than those who refrain from alcohol. Furthermore, more than 50 percent of teenagers say that sex while drinking or on drugs often produces unplanned pregnancies.[26] An Ohio study of high school girls who tried cocaine indicated that these adolescents were five times more likely to have experienced an unintended pregnancy than peers who avoided cocaine.[27]

* Dubbed the "poor man's cigarette" in India, bidis (pronounced beedies) are unfiltered cigarettes packed with tobacco flakes and hand-rolled in tendu, temburni, or other leaves that are secured with a string at one end. Bidis produced for the American market are flavored to taste like chocolate and various fruits or spices, making them more attractive to minors. Bidis look like marijuana cigarettes, are easy to buy, and are often cheaper than conventional cigarettes.

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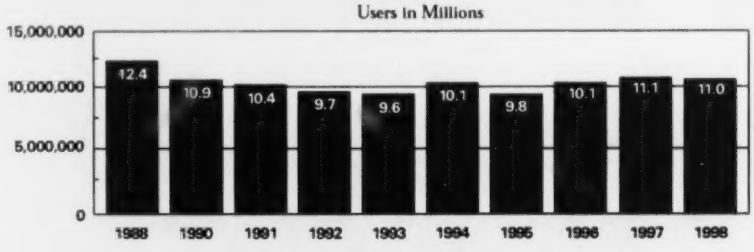
MARIJUANA

Overall usage — In 1998, eleven million (5 percent) of Americans aged twelve and older were current (past-month) marijuana users, similar to the 11.1 million (5.1 percent) reported in 1997. Approximately 81 percent of current illegal drug users were marijuana users.[28] An estimated 2.1 million Americans tried marijuana for the first time in 1997. This number increased from approximately 1.4 million in 1991 to 2.4 million in 1994; it has not changed significantly since 1994.[29]

Use among youth — The 1999 MTF shows that past-month marijuana use among eighth graders was stable during the past year, but decreased 14 percent since 1996. Lifetime, past-year, and past-month use of marijuana did not change in any grade between 1998 and 1999. In 1999, lifetime rates of marijuana use were 49.7, 40.9, and 22 percent for twelfth, tenth, and eighth graders, respectively. Past-year self-reported marijuana use by twelfth graders remained stable since 1997 (about 38 percent) - down from the 1979 peak of 50.8 percent. Among eighth graders, disapproval of "trying marijuana once or twice" increased from 69 to 70.7 percent between 1998 and 1999. Eighth graders who reported that marijuana was "fairly easy to get" dropped from 50.6 to 48.4 percent in the same time period. According to the PRIDE survey, monthly marijuana use for all students declined from 15.9 percent in 1997-98 to 14.4 percent in 1998-99.[30] The percentage of students who strongly agreed that "marijuana users in my school are popular" decreased from 17 to 10 percent.[31] A recent analysis by CASA on youth in rural America presents a different trend. Eighth graders in rural areas have a higher past-month marijuana rate (11.6 percent) than their peers in large metropolitan areas (8.6 percent).[32]

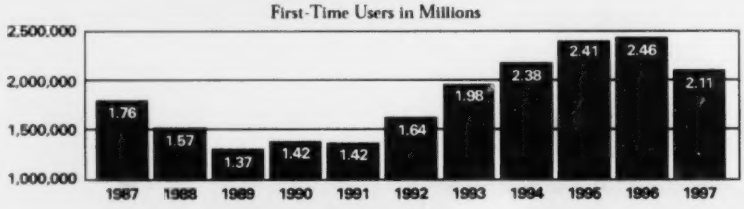
Availability — Marijuana is the most readily available illegal drug in the United States. According to the Drug Enforcement Administration (DEA), the majority of the marijuana in the U.S. is foreign-grown. Mexico, Colombia, and Jamaica are primary source nations; Canada, Thailand, and Cambodia are secondary sources.[33] Although the full scope of domestic marijuana cultivation is unknown, the National Drug Intelligence Center indicates that every state in the nation reports some level of cultivation.[34] Statistics from the 1998 Domestic Cannabis Eradication/Suppression Program show that the leading states for outdoor cannabis growth were

Current Marijuana Use (Past-Month)



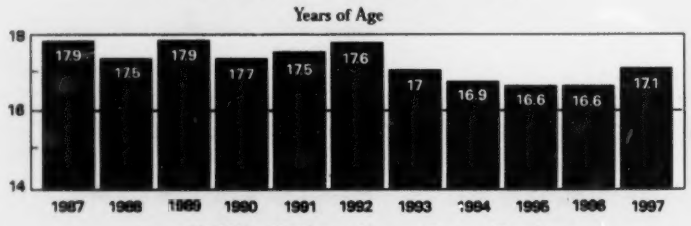
Source: SAMHSA, National Household Survey on Drug Abuse (various years)

Marijuana Initiation Rates



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Average Age of First Marijuana Use



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

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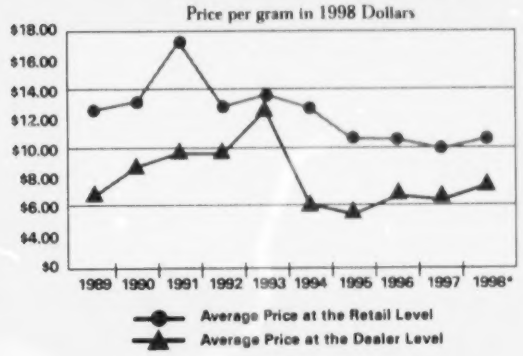
California, Hawaii, Kentucky, and Tennessee. Combined, these four states accounted for approximately 75 percent of the total outdoor-cultivated marijuana plants eradicated in 1998.[35] The largest instance of eradication in 1999 reported by the DEA was the June seizure of over fifty-one thousand outdoor plants near the Mississippi River in Arkansas.[36]

Indoor cultivation of marijuana provides a controlled environment conducive to year-round production of high-potency sinsemilla* and can be accomplished in a variety of settings from closets to elaborate greenhouses. Indoor cannabis cultivators frequently employ advanced agronomic practices such as cloning; hydroponics; and automatic light metering, irrigation, fertilizing, and insecticides to enhance the rate of growth. Nationally, drug law-enforcement authorities seized 232,839 indoor-grown marijuana plants in 1998, an increase from 225,232 in 1997.[37]

Prices for commercial-grade marijuana have remained relatively stable over the past decade, ranging from approximately $400 to $1,000 per pound in U.S. Southwest border areas to between $700 and $2,000 per pound in the Midwest and Northeast United States. According to data from the Potency Monitoring Project at the University of Mississippi, the tetrahydrocannabinol (THC) content of commercial-grade marijuana rose from an average of 3.71 percent in 1985 to an average of 5.57 percent in 1998.[38] The average THC content of U.S. produced sinsemilla increased from 3.2 percent in 1977 to 12.8 percent in 1997.[39]

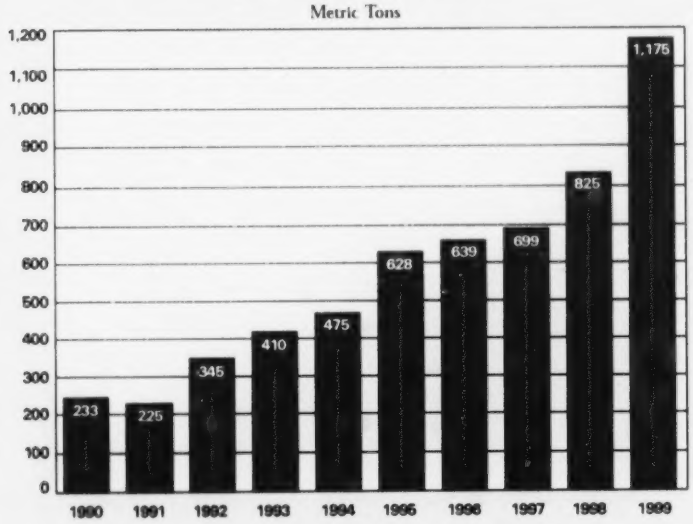
* Spanish for "without seed." These unpollinated flowering tops of the female *Cannabis sativa L.* plant are valued for high tetrahydrocannabinol (THC) content.

Average Price for Marijuana



*Based on annualized data through June 1998
Source: 1999 ONDCP Adjusted from DEA STRIDE data

Federal Marijuana Seizures



Source: DEA, Federal-wide Drug Seizure System (FDSS)

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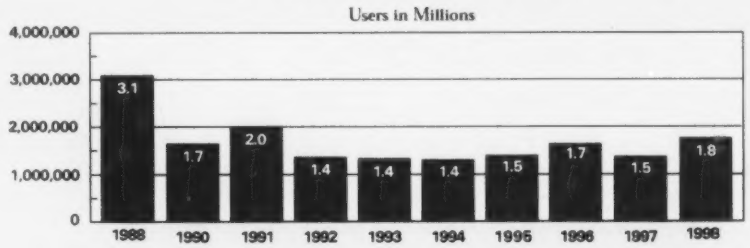
COCAINE

Overall usage — Cocaine use stabilized in the United States between 1992 and 1998. Past-month cocaine use declined from 3 percent of the population (5.7 million) in 1985 to 0.7 percent (1.4 million) in 1992, and did not change significantly through 1998. An estimated 1.8 million Americans were past-month cocaine users in 1998, a statistically insignificant increase from 1997 (1.5 million) and 1996 (1.7 million). The number of frequent and occasional* users of cocaine remained statistically unchanged since 1992. In 1998, the number of frequent users of cocaine was estimated at 595,000 compared to 682,000 in 1997. The number of occasional users decreased from 2.6 million in 1997 to 2.4 million in 1998.[40] In 1998, there were an estimated 3.3 million hardcore chronic users of cocaine in the United States. Between 1992 and 1998 the estimated number of hardcore chronic cocaine users remained relatively stable, ranging between 3.3 and 3.6 million.[41] Despite the stabilization of overall use since 1992, the number of first-time users of any form of cocaine rose between 1996 and 1997 from 670,000 to 730,000. This level is still lower than during the early 1980s when the new initiate figures were between 1.1 and 1.4 million per year.[42]

Use among youth — The 1999 MTF reported that among eighth graders, the rate of past-year use of crack cocaine declined 14 percent (from 2.1 to 1.8 percent) from 1998; this was the first such decrease in the 1990s. In 1999 the rate of past-month use of crack cocaine among tenth graders dropped 27 percent (1.1 to 0.8 percent) from 1998; twelfth graders were the only youth group that did not report a decline in past-month use. The perceived harmfulness among twelfth graders for trying crack once or twice fell 8 percent (from 52.2 to 48.2 percent) between 1999 and 1998.[43]

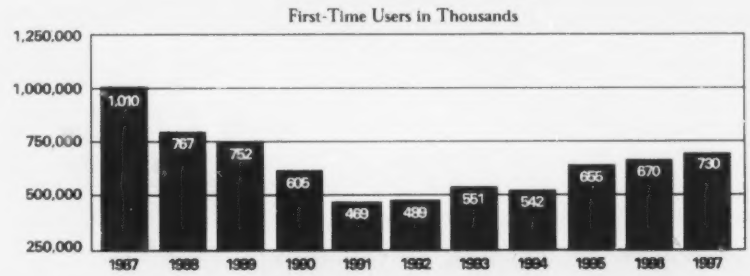
* A frequent user is defined as one who uses a controlled substance on fifty-one or more days during the past year. An occasional user is defined as one who uses a controlled substance on twelve or fewer days during the past year.

Current Cocaine Use (Past-Month)



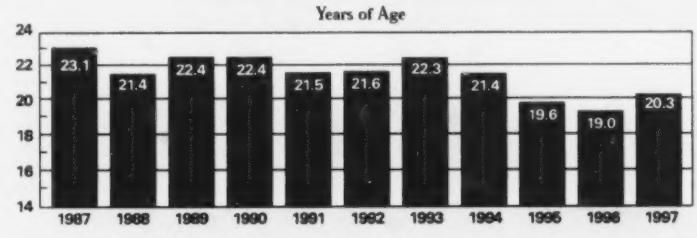
Source: SAMHSA, National Household Survey on Drug Abuse (various years)

Cocaine Initiation Rates



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Average Age of First Cocaine Use



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

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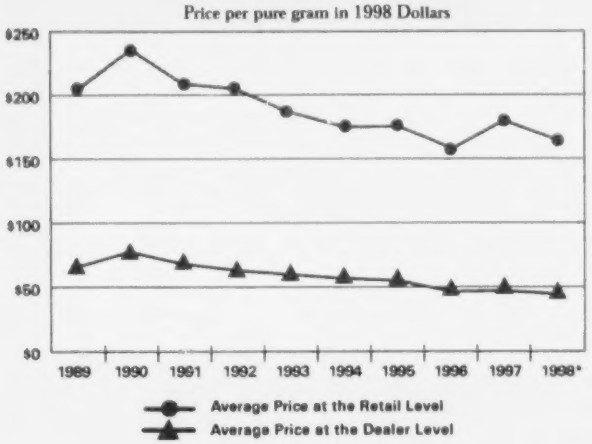
Availability — Cocaine continues to be readily available in nearly all major metropolitan areas.[44] The August 1999 report of the Semiannual Interagency Assessment of Cocaine Movement estimated that 174 metric tons of cocaine arrived in the United States in the first six months of 1999.[45] Approximately 60 percent of the cocaine smuggled into the U.S. crosses the Southwest border.[46]

Over the past three years, domestic cocaine availability has been estimated at 347 metric tons for 1996, 281 metric tons for 1997, and 301 metric tons for 1998. These estimates were developed by an ONDCP-sponsored drug flow analysis using a composite model that integrates four independent measures of cocaine availability, from both a consumption approach and several supply approaches.[47] Since 1989, the average retail purity of cocaine remained relatively stable — between 65 and 80 percent.[48] Similarly, the retail price of pure cocaine has remained relatively stable since 1994 at $170 per pure gram.[49] Law-enforcement agencies throughout the nation continue to report serious problems with cocaine, crack, and related criminal activity. Approximately 60 percent of agencies queried by NDIC reported cocaine as the greatest threat.[50]

Average Price For Cocaine

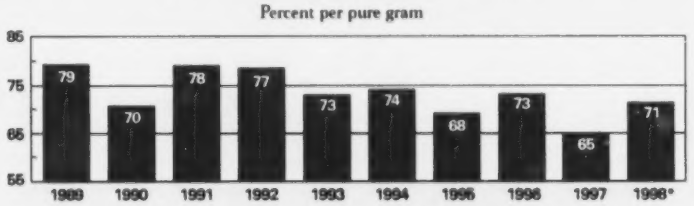
Price per pure gram in 1998 Dollars



*Based on annualized data through June 1998
Source: 1999 ONDCP-Adjusted from DEA STRIDE Data

Cocaine Purity at the Retail Level

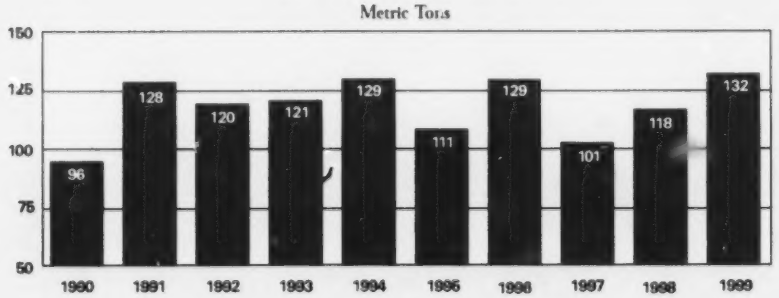
Percent per pure gram



*Based on annualized data through June 1998
Source: 1999 ONDCP-Adjusted from DEA STRIDE Data

Federal Cocaine Seizures

Metric Tons



Source: DEA, Federal wide Drug Seizure System (FDSS)

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HEROIN

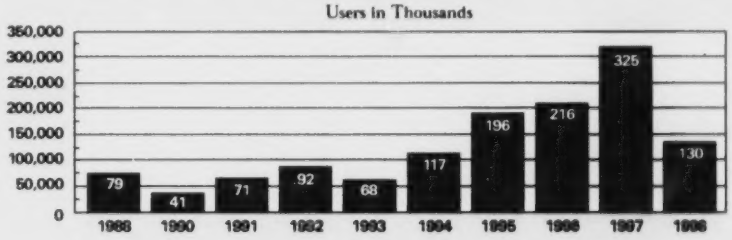
Overall usage — Heroin use in the United States appears to be declining after an upward trend between 1992 and 1997. The estimated number of current heroin users was 216,000 in 1996, 325,000 in 1997, and 130,000 in 1998.[51] The number of past-year heroin users decreased significantly from 597,000 in 1997 to 253,000 in 1998.[52] There was also a statistically significant upward trend in the number of new heroin users from 1992 to 1996. While not a statistically significant change, there were 81,000 new heroin users in 1997, down from 149,000 in 1996.[53] Cautious evaluation of this data is necessary because the NHSDA cannot accurately measure rare or stigmatized drug use, relying as it does on self-reporting and on people residing in households. In alternate research, the number of hardcore* users of heroin in 1998 was estimated to be 980,000, compared to 935,000 in 1997 (not a statistically significant difference).[54]

Injection remains the most prevalent method of ingestion, particularly for low-purity heroin. The increased availability of high-purity heroin and the fear of infection from the Human Immuno-deficiency Virus (HIV), sometimes transmitted through shared needles, has made snorting and smoking the drug more common. In addition to avoiding the negative stigma of intravenous drug use, some teenager heroin users smoke or snort heroin under the false impression that such routes of admission are less addictive.

Use among youth — In 1999, lifetime use of heroin was 2.3 percent for eighth graders, 2.3 percent for tenth graders, and 2 percent for twelfth graders. Between 1998 and 1999, heroin use did not change in any grade level. However, lifetime use of heroin increased consistently since 1991 when reported rates were 1.2 percent for eighth graders, 1.2 percent for tenth graders, and 0.9 percent for

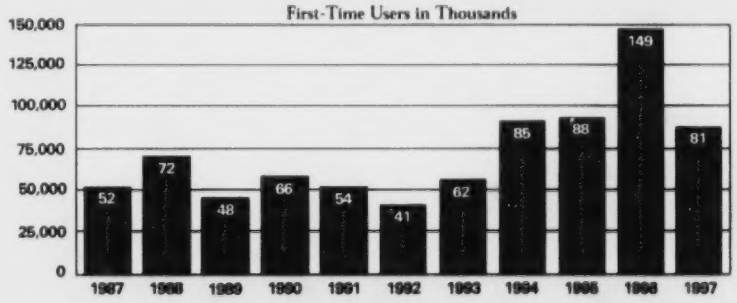
* Defined as one who used a controlled substance at least one or two days every week during the past year or more than ten days during the previous month.

Current Heroin Use (Past-Month)



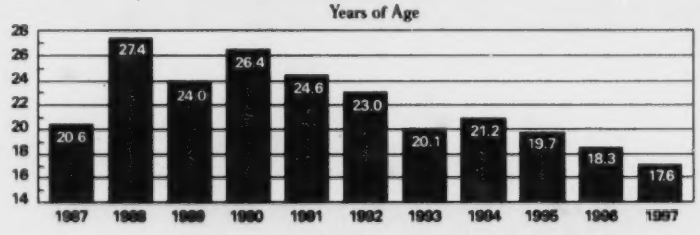
Source: SAMHSA, National Household Survey on Drug Abuse (various years)

Heroin Initiation Rates



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

Average Age of First Heroin Use



Source: SAMHSA, 1998 National Household Survey on Drug Abuse

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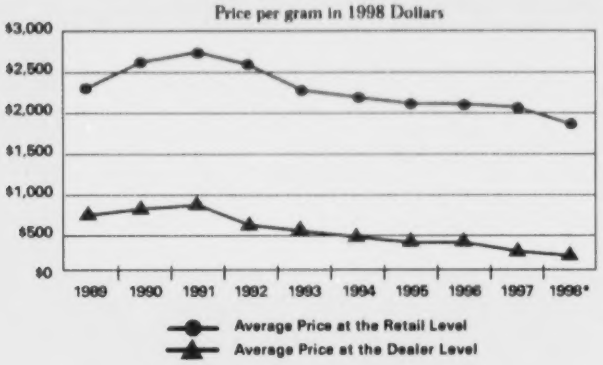
twelfth graders. The average age of new heroin users has been dropping since 1994, from 21.2 years to 17.6 years in 1997.[55]

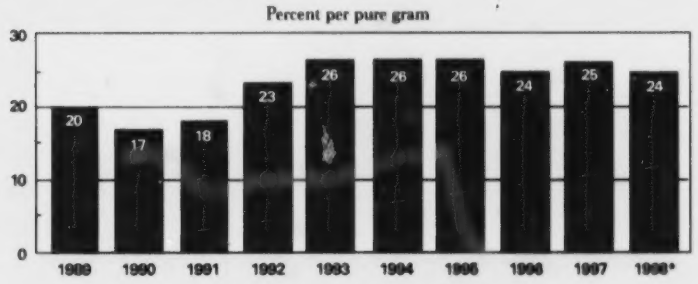
Availability — Heroin purity is a reflection of the drug's availability. Unprecedented retail purity and low prices in the United States indicate that heroin is readily accessible.[56] When the drug is hard to find, it is cut with other substances. High purity levels may also reflect changes in trafficking patterns. A decrease in the number of middlemen involved in getting South American and Mexican heroin to customers bypasses mid-level individuals and minimizes cutting and adulteration that historically has reduced heroin purity. For example, the Central Florida High Intensity Drug Trafficking Area reports heroin sampled from past-year seizures with purity levels up to 97 percent.[57] High purity can have devastating consequences - 119 heroin overdose deaths occurred in Oregon during the first six months of 1999, a 75 percent increase compared to the first six months of 1998.[58] Consumption-based modeling estimates that U.S. heroin availability increased from 12.5 metric tons in 1998 to 12.9 metric tons in 1999.[59] A supply-based approach has also been used to estimate heroin availability, applying data from DEA's Heroin Signature Program and potential production estimates. This methodology has resulted in an estimate of 16 metric tons of domestically available heroin.

Average Price For Heroin



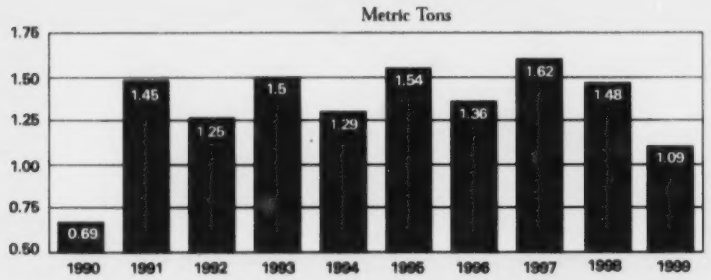
*Based on annualized data through June 1998
Source: 1999 ONDCP-Adjusted from DEA STRIDE Data

Heroin Purity at the Retail Level



*Based on annualized data through June 1998
Source: 1999 ONDCP-Adjusted from DEA STRIDE Data

Federal Heroin Seizures



Source: DEA, Federal-wide Drug Seizure Systems (FDSS)

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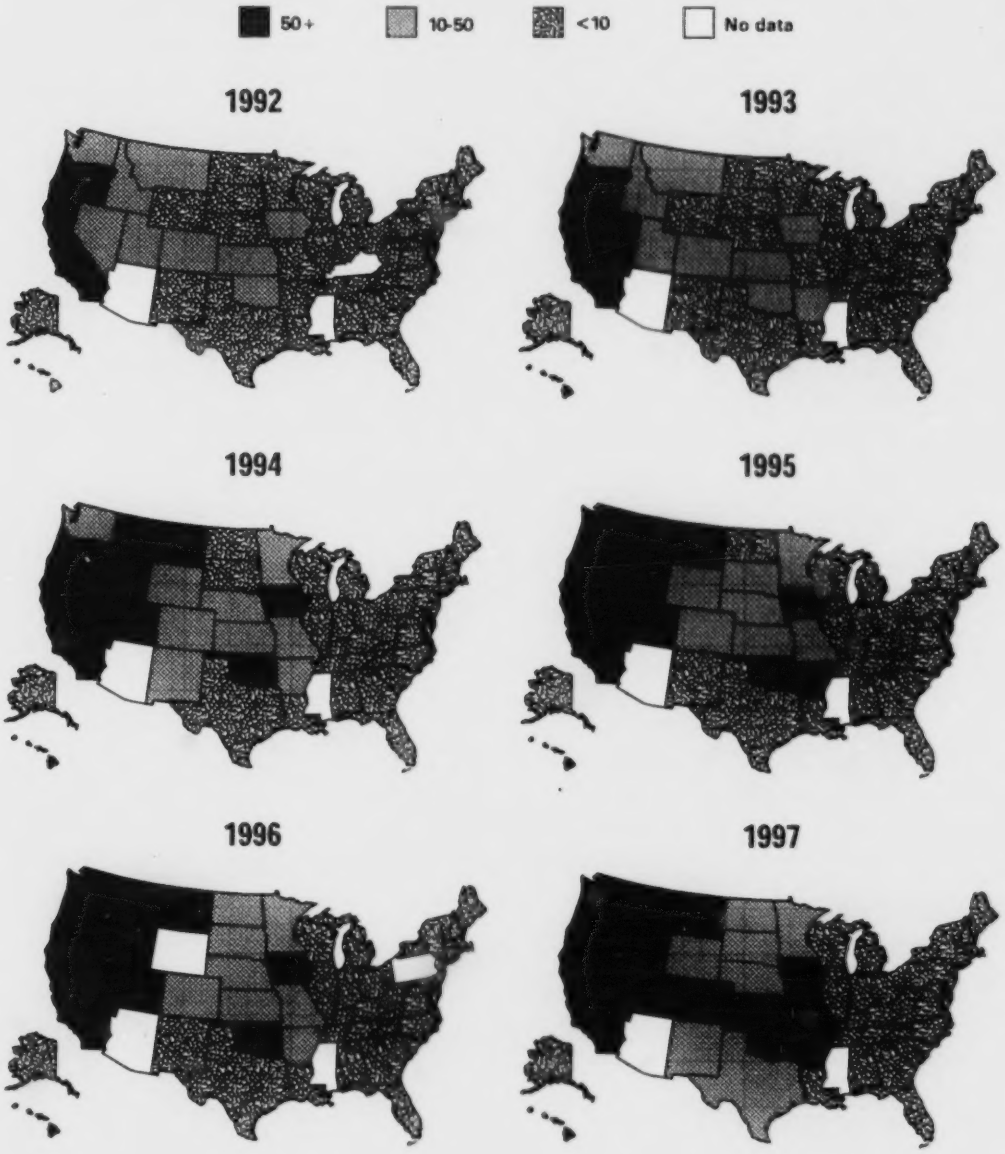
The Spread of Methamphetamine

Methamphetamine Treatment Admission Rates (per 100,000)



Source: SAMHSA, OAS, TEDS

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METHAMPHETAMINE

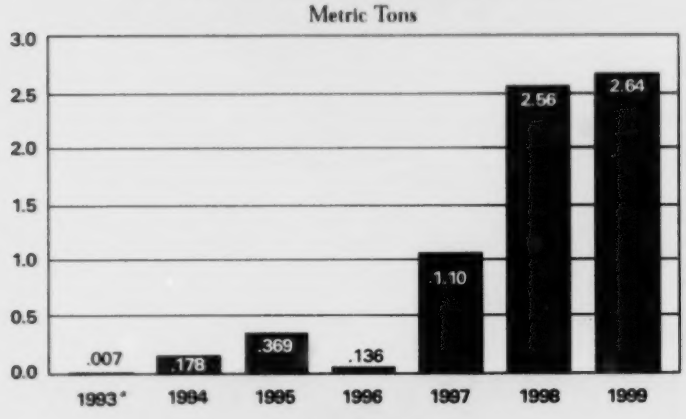
General — Methamphetamine is a highly addictive stimulant that can be manufactured using products commercially available anywhere in the United States. The stimulant effects from methamphetamine can last for hours, instead of minutes as with crack cocaine. Many methamphetamine users try to alleviate the effect of a methamphetamine "crash" by buffering the drug with other substances like alcohol or heroin. As is the case with heroin and cocaine, methamphetamine can be snorted, smoked, or injected. The chemicals used in producing methamphetamine are extremely volatile, and the amateur chemists running makeshift laboratories can cause deadly explosions and fires. The by-products of methamphetamine production are extremely toxic and present a threat to the environment. The El Paso Intelligence Center estimates that clandestine methamphetamine laboratories, each of which costs between $3,100 and $150,000 to clean up (depending on size), produce as much as twenty metric tons of toxic waste each year.[60] Methamphetamine traffickers display no concern over environmental hazards when manufacturing the drug and disposing of its chemical by-products.

Overall usage — In 1998, the estimated number of persons who tried methamphetamine in their lifetime was 2.1 percent of the population (4.7 million). The 1998 figure was similar to 1997 and 1994 (2.5 percent and 1.8 percent), respectively.[61] While use of this drug is spreading east, methamphetamine continues to be more common in the western U.S. The number of hardcore methamphetamine users in 1998 was estimated to be 356,000 compared with 310,000 in 1997.[62]

Use among youth — According to the 1999 MTF,* use of ice (crystal methamphetamine) among twelfth graders decreased from 3 percent in 1998 to 1.9 percent in 1999.[63] Data for crystal methamphetamine were only available for this age group in the MTF survey. A statistically significant decrease in lifetime methamphetamine use among twelve to seventeen-year-olds occurred during 1997 to 1998, dropping from 1.2 to 0.6 percent.[64] In the most recent CASA report, past-month methamphetamine use for eighth graders in rural areas is 5.1 percent versus 2.5 percent for their peers in larger cities.[65]

* The 1999 Monitoring the Future study asked twelfth graders only two of six questionnaire forms about their use of crystal methamphetamine. Consequently, small estimates resulted, and the reduced sample size may cause a lack of reliability in measuring long-term trends.

Federal Methamphetamine Seizures



Partial year data
Source: DEA, Federal-wide Drug Seizure System (FDSS)

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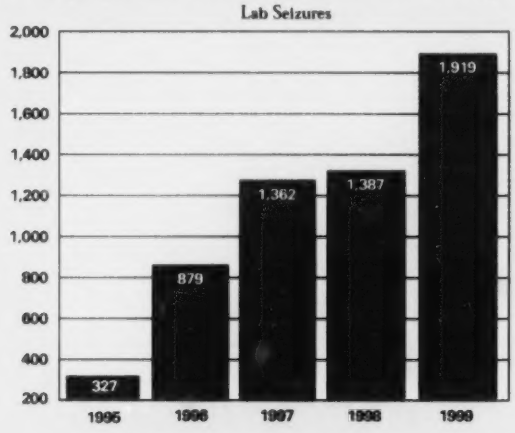
Availability — Methamphetamine is the most prevalent synthetic drug clandestinely manufactured in the United States.[66] Historically, the methamphetamine problem has been concentrated in the west and southwestern United States. It is now in most major metropolitan areas (except in the northeast) and is emerging in small towns and rural communities.[67] Methamphetamine manufacturing is experiencing unprecedented growth. The total number of clandestine laboratories seized in 1998 exceeded 3,800.[68] Clandestine laboratory seizures by the DEA alone increased from 1,382 in 1998 to 1,919 in 1999.[69] From January 1998 to June 1999, the Iowa Division of Narcotics Enforcement (operating in conjunction with the Midwest HIDTA) seized 522 labs – a 442 percent increase from 1996 through 1997.[70] This increase in seizures may reflect efforts by individuals operating small clandestine laboratories on the periphery of the methamphetamine market to exploit demand for the drug and satisfy personal use.[71]

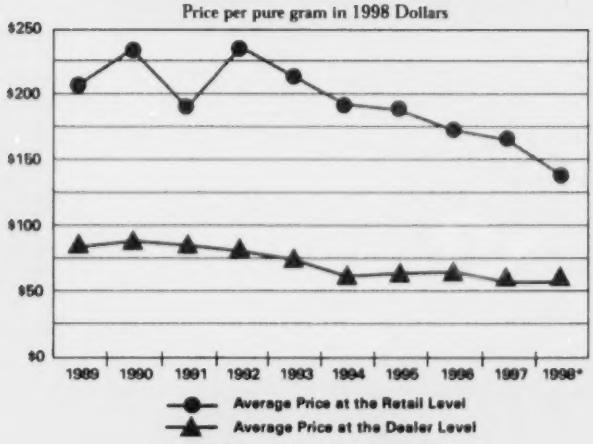
Large drug-trafficking organizations continue to be the United States' major source of methamphetamine. According to consumption-based modeling estimates, U.S. methamphetamine availability at the retail level increased from 11.7 metric tons in 1997 to 15.9 metric tons in 1998.[72] The average retail price per pure gram of methamphetamine has been decreasing since 1992.[73]

Methamphetamine Clandestine Lab Seizures by the DEA



Source: Drug Enforcement Administration

Average Price For Methamphetamine



**Based on annualized data through of 1998*
Source: 1999 ONDCP-Adjusted from DEA STRIDE Data

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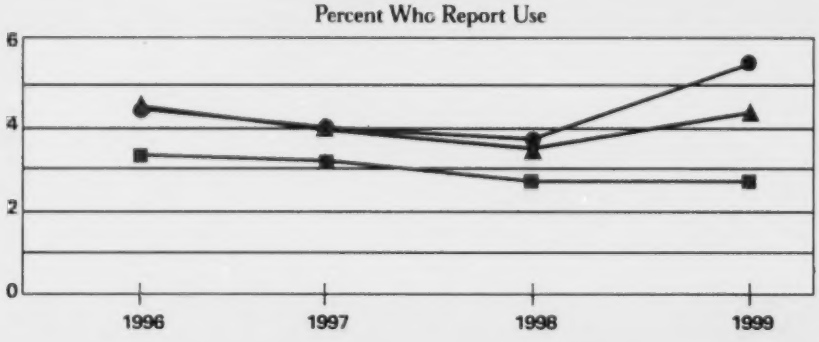
MDMA

General — MDMA (3,4-methylenedioxymethamphetamine), commonly called ecstasy or XTC, is a synthetic, psychoactive drug possessing stimulant and mild hallucinogenic properties. The substance gained popularity in the late 1980s and early 1990s as an alternative to heroin and cocaine. MDMA customarily is sold and consumed at "raves," which are semi-clandestine, all-night parties and concerts. Use appears to be widespread within virtually every major U.S. city with indications of trafficking and abuse in smaller towns. MDMA is considered a "designer drug," which is a substance on the illegal market that is a chemical analogue or variation of another psychoactive drug. MDMA is similar in stimulant properties to amphetamine or methamphetamine, and it resembles mescaline in terms of hallucinogen qualities. Illicitly marketed as a "feel good" drug, it has been dubbed the "hug drug." Risks associated with MDMA include severe dehydration and death from heat stroke or heart failure.[74] A review of several studies by the National Institute on Drug Abuse (NIDA) concludes that heavy MDMA users have significant impairments in visual and verbal memory compared to non-users.[75] Further findings by Johns Hopkins University and the National Institute of Mental Health (NIMH) suggest that MDMA use may lead to impairment in other cognitive functions, such as the ability to reason verbally or sustain attention.[76]

Overall Usage — Ecstasy is often used in conjunction with other drugs and is extremely popular among some teenagers and young professionals. Furthermore, growing numbers of users - primarily in the Miami and Orlando areas - combine MDMA with heroin, a practice known as "rolling." If this trend continues, MDMA may become a "gateway" drug that leads to the consumption of a variety of other substances. Emergency room mentions increased from sixty-eight in 1993 to 637 in 1997.[77] MDMA also suppresses the need to eat, drink, or sleep and subsequently allows people to stay up all night, dancing at raves.[78]

Use among youth — According to the 1999 MTF, past-year use of MDMA increased from 3.3 percent in 1998 to 4.4 percent in 1999 among tenth graders. Twelfth grade use increased in all three categories by: 38 percent for lifetime use (5.8 percent to 8 percent), 56 percent for annual use (from 3.6 percent to 5.6 percent), and 67 percent for past 30-day use (from 1.5 percent to 2.5 percent) between 1998 and 1999.[79] MDMA use is widespread, particularly among white adolescents in the Northeast.

Ecstasy (MDMA) and Our Youth
Trends in Annual Use



	1996	1997	1998	1999
12th Grade	4.6	4	3.6	5.6
10th Grade	4.6	3.9	3.3	4.4
8th Grade	3.4	3.2	2.7	2.7

Source: 1999 Monitoring the Future Study

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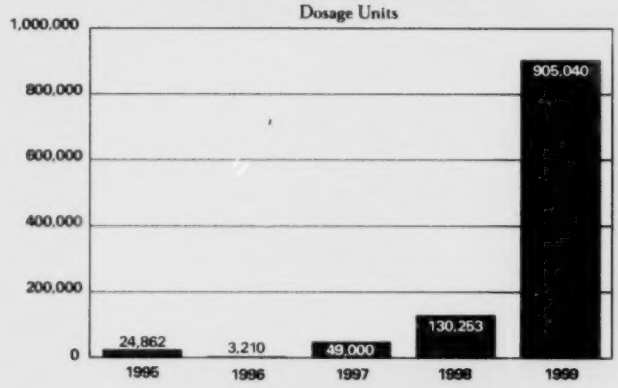
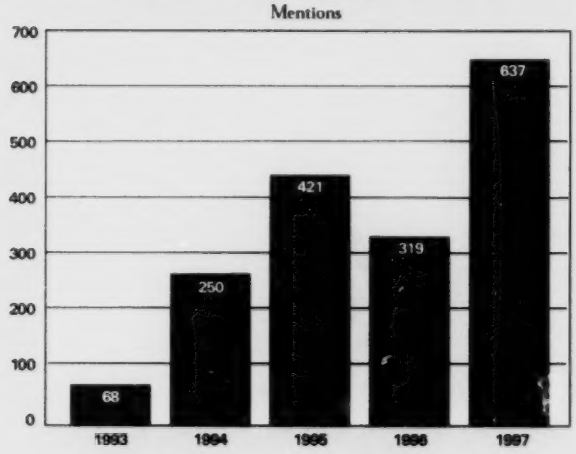
Availability — Numerous data reflect the increasing availability of MDMA in the United States - in metropolitan centers and suburban communities alike.[80] Law-enforcement agencies report a surge in MDMA seizures between 1998 and 1999. The DEA seized more than 216,300 MDMA tablets in the United States in the first five months of 1999; the 1998 total was 143,600.[81] The United States Customs Service (USCS) reports that seizures are up more than 700 percent since 1997. USCS seized three million MDMA tablets in fiscal year 1999 and two million to date in the first quarter of fiscal year 2000.[82] Production of MDMA is centered in Europe (predominately Belgium, the Netherlands, and Luxembourg).[83] Further encouraging the importation of MDMA to the United States is the drug's high profit margin - production costs are as low as two to twenty-five cents per dose while retail prices in the U.S. are between twenty dollars and forty-five dollars per dose.[84] Increasing involvement of organized criminal groups - particularly Western European, Russian, and Israeli crime syndicates - indicates a move toward "professionalization" of MDMA markets. Law-enforcement reports indicate criminal groups that have proven capable of producing and smuggling significant quantities of MDMA into the United States are expanding distribution networks from coast to coast.[85]

Federal MDMA (Ecstasy) Seizures



Source: DEA, 1999 STRIDE Data

Ecstasy (MDMA) Emergency Room Mentions



Source: SAMHSA, 1997 DAWN Emergency Department Data

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INHALANTS

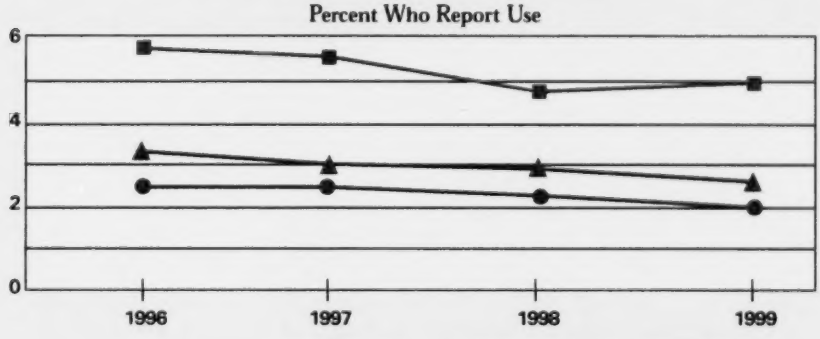
General — The term "inhalants" refers to more than a thousand different household and commercial products that can be intentionally abused by sniffing or "huffing" (inhaling through one's mouth) for an intoxicating effect. These products are composed of volatile solvents and substances commonly found in commercial adhesives, lighter fluids, cleaning solutions, and paint products. Their easy accessibility, low cost, and ease of concealment make inhalants one of the first substances abused by many young Americans.

Overall usage — There were an estimated 708,000 new inhalant users in 1997, compared to 710,000 in 1996.[86] For inhalants, the overall rate of past-month use remained steady since 1991 (between 0.3 and 0.4 percent from 1991 through 1998). Inhalants can be deadly, even with first-time use.

Use among youth — The 1998 NHSDA reports that among youth, current-use rates for inhalants decreased from 2 percent in 1997 to 1.1 percent in 1998. The 1999 MTF reported that there were no statistically significant differences in inhalant use between 1998 and 1999. However, among eighth graders, disapproval of trying inhalants increased by 3 percent (from 83 to 85.2 percent) from 1998 to 1999. Among tenth graders, the perceived harmfulness (i.e., "great risk") of trying inhalants "once or twice" increased 5 percent (45.8 to 48.2 percent) from 1998 to 1999. This change was accompanied by a 4 percent increase (from 73.3 to 76.3 percent) in perceived harmfulness of regular inhalant use. During the nine years for which data are available for eighth graders, lifetime, past-year, and past-month inhalant use peaked in 1995. Inhalant abuse continues to be more prevalent among eighth graders than tenth and twelfth graders. According to the PRIDE survey, monthly inhalant use for all students declined from 3.3 percent in 1997-98 to 2.9 percent in 1998-99.[87]

Availability — Inhalant abuse typically involves substances readily available in any home or school. Examples include: adhesives (airplane glue, rubber cement), aerosols (spray paint, hair spray, air freshener), cleaning agents (spot remover, degreaser), food products (vegetable cooking spray, canned dessert topping), gases (butane, propane), solvents and gases (nail polish remover, paint thinner, typing correction fluid, lighter fluid, gasoline).

Inhalants and Our Youth
Trends in Current (Past-Month) Use



	1996	1997	1998	1999
12th Grade	2.5	2.5	2.3	2.0
10th Grade	3.3	3	2.9	2.6
8th Grade	5.8	5.6	4.8	5

Source: 1999 Monitoring the Future Study

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OTHER ILLICIT SUBSTANCES

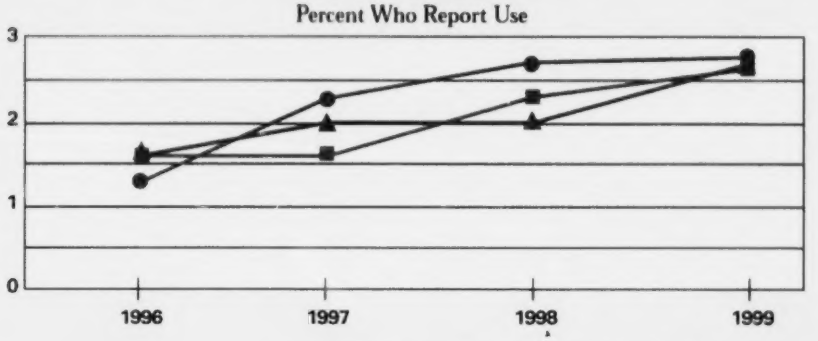
Overall usage — The 1999 MTF reports that use of hallucinogens, LSD, and PCP remained stable. The 1998 NHSDA reports no major changes in the prevalence of non-medical use of psychotherapeutics for adolescents aged twelve and older between 1997 and 1998. The rate of current hallucinogens use did not change significantly between 1997 and 1998 (0.8 percent versus 0.7 percent, respectively). There were an estimated 1.1 million new hallucinogen users in 1997, nearly twice the annual average during the 1980s. Data are not available to describe emerging threats from other illicit substances like ketamine, gamma-hydroxybutyrate (GHB), gamma-butyrolactone (GBL), and rohypnol. Nevertheless, ethnographers continue to report "cafeteria use"* of hallucinogenic or psycho-sedative drugs like ketamine, LSD, and GHB. The increasing popularity of "raves" within the dance culture has sparked a resurgence of designer drugs.

Steroid use is becoming more prevalent among adolescents. The repercussions of steroid use are enormous. Among teens, steroid use can lead to an untimely halting of growth due to premature skeletal maturation and accelerated puberty changes. All steroid users risk liver tumors, high blood pressure, severe acne, and trembling. Many of these effects are irreversible.[88]

Use among youth — The 1999 MTF reports past-year use of rohypnol among eighth graders decreased from 0.8 percent in 1998 to 0.5 percent in 1999 - a statistically significant change. Past-year use of rohypnol for both tenth and twelfth graders was 1.0 percent in 1999 - a statistically insignificant change from 1998. Past-year use of steroids increased from 1.2 percent in 1998 to 1.7 percent in 1999 for both eighth and tenth graders. Past-month use still remains under 1 percent for eighth and tenth graders, in spite of increases in 1999 (e.g., 0.5 percent in 1998 to 0.7 percent in 1999). Lifetime use of steroids increased among tenth graders from two percent in 1998 to 2.7 percent in 1999.[89]

* Denotes the proclivity to consume any readily available drug. Young people often take mood-altering pills or consume drugged drinks in night clubs without knowing what the drug is or the dangers posed by its use, alone or in combination with alcohol and other drugs.

Steroids and Our Youth
Trends in Lifetime Use



	1996	1997	1998	1999
12th Grade	1.9	2.4	2.7	2.9
10th Grade	1.6	2	2	2.7
8th Grade	1.6	1.6	2.3	2.7

Source: 1999 Monitoring the Future Study

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Availability — The Community Epidemiology Working Group reports that designer drugs in most parts of the country are easily obtainable and used primarily by adolescents and young adults at clubs, raves, and concerts.[90] GBL and 1,4-butanediol (both chemical precursors to GHB) are easily obtainable over the Internet. Individuals seeking illicit substances can also exploit Internet sites specializing in the sale of veterinary pharmaceuticals and prescription medications.

Controlled Substances Diversion — Attention must be paid to the misuse of a great variety of pharmaceuticals, narcotics, depressants, and stimulants. Manufactured in the United States and overseas to meet legitimate medical needs, these drugs are subject to diversion into the illicit trade.[91] Of the 2.4 billion prescriptions written in 1998, approximately 254 million were for controlled substances. An unknown quantity is diverted into illicit traffic, but legally controlled substances account for over 30 percent of all reported deaths and injuries associated with drug abuse.[92] In 1999, the United States Customs Service seized 9,275 packages containing prescription drugs — about 4.5 times as many as in 1998. The number of pills and tablets impounded by the Customs Service jumped to 1.9 million from 760,720 in 1998.[93] Likewise, DEA arrests for pharmaceutical diversions increased to 701 in 1999 from 410 in fiscal year 1998.[94] The availability of "prescription-free pharmaceuticals" via the Internet and overseas pharmacies represents an emerging challenge for the United States.[95] This challenge has been exacerbated by Internet pharmacies shipping medications via "express consignment operators" (ECO; i.e. FedEx, UPS, DHL, etc.) rather than the U.S. Postal Service. USCS prescription drug seizures from ECOs jumped from 294 in fiscal year 1998 to 518 in fiscal year 1999.

Precursor Chemicals — Of all the major drugs of abuse, only marijuana is available as a natural, harvested product. The others must be manufactured using various chemicals and techniques. Illegal drug trafficking is heavily dependent on the availability of commodities from legitimate sources in order to obtain the substances required for criminal production or synthesis.[96] Traffickers are able to obtain chemicals in large quantities at relatively low cost as a result of ignorance, indifference, or collusion by pharmaceutical distributors and international brokers.[97] An intensive training program conducted by the DEA's Office of Diversion Control in 1997 and 1998 increased the number and level of chemical diversion investigations in 1999. To address the problem of chemical diversion, various legislative measures, cooperative law-enforcement programs, and multilateral agreements have been enacted.

THE LINK BETWEEN DRUGS AND CRIME

While national crime rates in general continue to decline, almost 1.6 million Americans were arrested for drug-law violations in 1998.[98] Many crimes like murder, assault, prostitution, and robbery are often committed under the influence of drugs and alcohol or may be motivated by a need to obtain money for drugs. Substance abuse is frequently a contributing factor in family violence, sexual assaults, and child abuse.

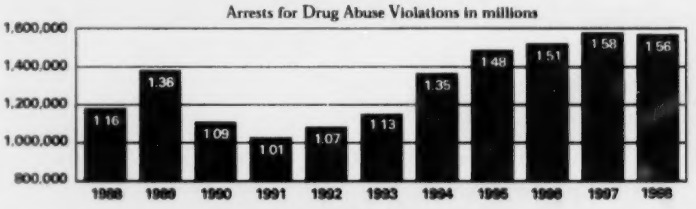
Arrestees often test positive for recent drug use — The National Institute of Justice's (NIJ's) Arrestee Drug Abuse Monitoring (ADAM) drug-testing program found that more than two-thirds of adult male arrestees and half of juvenile male arrestees tested positive for at least one drug in thirteen of thirty-five sites in 1998. Marijuana was the drug most frequently detected among both groups.[99] The percentages of persons who tested positive for cocaine declined between 1997 and 1998 in a majority of the twenty-three sites for which trend data were available although substantial variation existed between the geographical regions sampled.[100] Multiple drug use remains an endemic problem among arrestees, and more than two-thirds of the individuals who tested positive for opiates also tested positive for another drug.[101]

Heroin use among arrestees remains relatively stable. There has been little change in the prevalence of opiates among ADAM arrestees or the population that uses opiates. As has been the case in previous years, in 1998 female arrestees were more likely to test positive for opiates than male arrestees. In 1998, male arrestees showed opiate-positive rates higher than female arrestees by at least four percent in only four sites: three veteran (Cleveland, New Orleans, and St. Louis) and one new one (Laredo).[102] Marijuana use continues to be a significant problem among young adult offenders, particularly males. None of the thirty-five ADAM sites reported less than 20 percent of the adult male samples testing positive. In Oklahoma City, 87 percent of the fifteen to twenty-year-old male arrestees tested positive for marijuana.[103]

The year 1998 offered relatively little change over 1997 for most communities with respect to methamphetamine use among arrestees. It continued to appear only sporadically outside western ADAM sites and showed no sign of geographic expansion.[104] Such data are unusual considering the violent behavior sometimes associated with methamphetamine use. In a survey conducted by the National Drug Intelligence Center, approximately 35 percent of the law-enforcement agencies that were queried identified methamphetamine as their greatest threat.[105]

Drug-Related Arrests

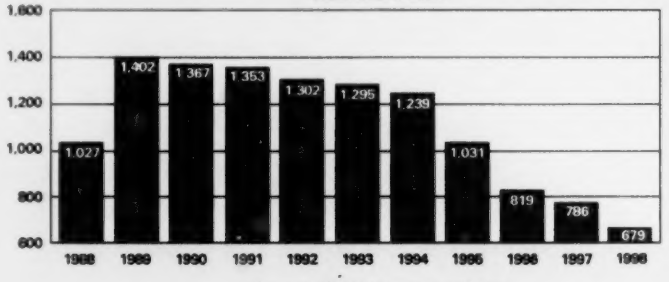
Arrests for Drug Abuse Violations in millions



Source: 1999 FBI Uniform Crime Reports

Drug-Related Murders

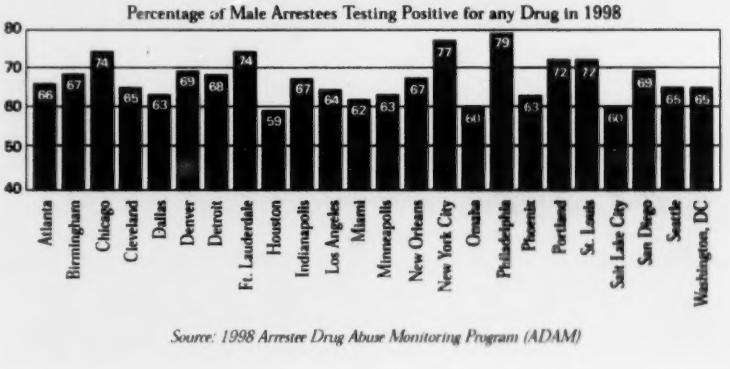
Number of Deaths



Source: 1999 FBI Uniform Crime Reports

Drug Use Correlates with Crime

Percentage of Male Arrestees Testing Positive for any Drug in 1998



Source: 1998 Arrestee Drug Abuse Monitoring Program (ADAM)

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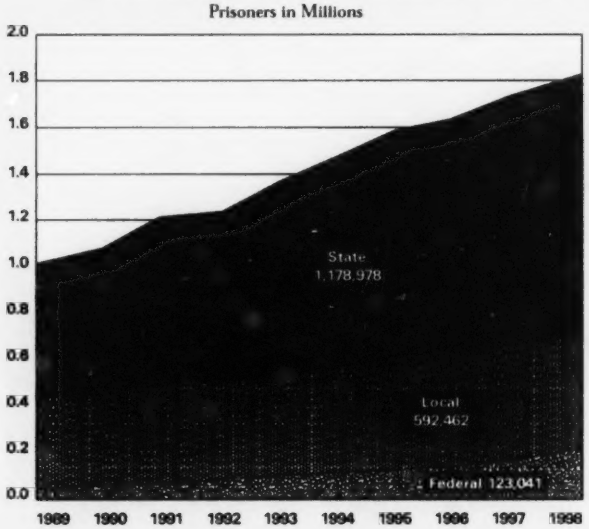
Nearly one in four inmates are drug offenders — State and federal prison authorities reported that 1,232,900 people were physically in their custody at the end of the 1998.[106] One in every 113 men in the United States was incarcerated in a state or federal prison at that time.[107] More Americans were behind bars than on active duty in the armed forces. The number of sentenced prisoners rose 4.8 percent in 1998. Between 1990 and 1998, the number of female inmates serving time for drug offenses in state prisons was up by 12,000, and drug offenders accounted for 19 percent of the total growth in the state inmate population.[108] Nearly 60 percent of the inmates in the federal prison system in 1997 were sentenced for drug offenses, up from 53 percent in 1990.[109] In 1997, 19,115 people were sentenced in federal court for drug violations. Almost all (94 percent) these drug offenders were convicted of drug trafficking. Drug offenders in state and federal prison have extensive criminal histories. More than half (53 percent) of state inmates and 24 percent of federal prisoners were on probation or parole at the time of their current offense. More than eight in every ten state inmates and six of ten federal inmates had prior sentences. Nearly half (45 percent) of state inmates and a quarter of federal inmates had three or more prior sentences. Approximately, one in every four drug offenders within state prison had been sentenced previously for violent offenses.

State, Local, and Federal Incarceration Levels



Source: 1999 Bureau of Justice Statistics Bulletin

This high rate of incarceration is spread disproportionately among different racial/ethnic groups. In 1997 the rate of incarceration for African-American males was 3,209 per 100,000 compared to 1,273 for Hispanic males and 386 for white males.[110] A March 1997 study by the Bureau of Justice Statistics (BJS) found that black men were nearly twice as likely to be incarcerated (28.5 percent) as Hispanic men (16.0 percent) and six times more likely than white men (4.4 percent).[111]

Costs for incarceration continue to rise. In 1996 state correction expenses for prisons exceeded $22 billion, an increase of 83 percent from 1990 (in constant dollars).[112] State spending per resident for corrections operations have increased faster than spending on health, education, and natural resources. State spending for corrections totaled $994 per capita in 1998, more than twelve times larger than expenditures for education.

Substance abuse, family violence, and child maltreatment — Researchers have found that one-fourth to one half of men who commit acts of domestic violence also have substance-abuse problems. Women who abuse alcohol or illegal drugs are more likely to become victims of domestic violence than non-abusing women. Minors in the child welfare system whose parents have substance-abuse problems are more likely to have been victims of neglect than other children in similar situations, and more likely be placed in foster care than remain at home. Children of substance-abusing parents tend to stay in foster care for longer periods of time.[113] In a January 1999 report, the National Center on Addiction and Substance Abuse at Columbia University (CASA) estimated that drug abuse causes or contributes to seven of ten cases of child maltreatment and accounts for some ten billion dollars in federal, state, and local government spending on child welfare programs.[114]

Drugs, violence, and sexual crimes — The nexus between drugs, violence, and sexual crimes is abundantly clear. Alcohol is implicated in more incidents of sexual violence, including rape and child molestation, than any other drug. Alcohol use — by the victim, perpetrator, or both — is involved in 46 to 75 percent of date rapes among college students. Two-thirds of sexual offenders in state prison were under the influence of alcohol or other drugs at the time of the crime; 15 percent were under the influence of both alcohol and other drugs; and 5 percent were under the influence of drugs alone.[115]

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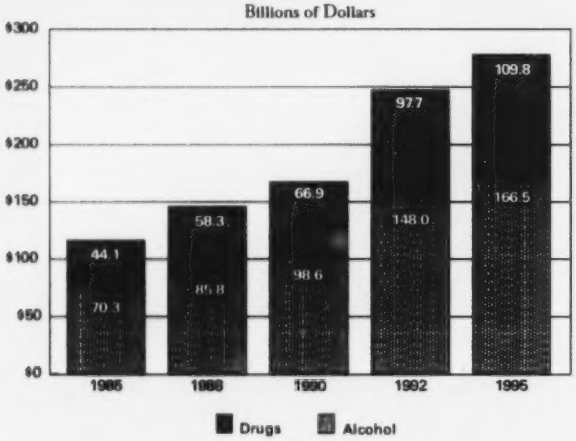
THE CONSEQUENCES OF ILLEGAL DRUG USE

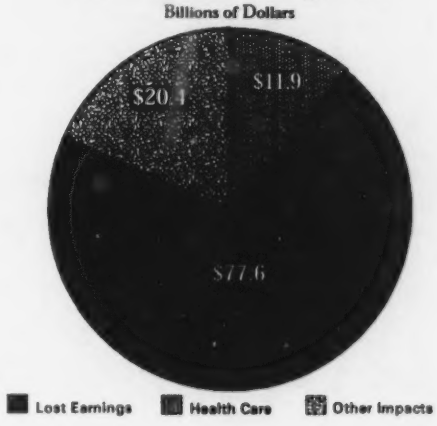
Increased crime, domestic violence, accidents, illness, lost job opportunities, and reduced productivity can be linked to illegal drug use. Every year Americans of all ages engage in unhealthy, unproductive behavior as a result of substance abuse.

Economic loss — Illegal drugs exact a staggering cost on American society. In 1995, they accounted for an estimated $110 billion in expenses and lost revenue.[116] This public-health burden is shared by all of society, directly or indirectly. Tax dollars pay for increased law enforcement, incarceration, and treatment to stem the flow of illegal drugs and counter associated negative social repercussions. NIDA estimated that health-care expenditures due to drug abuse cost America $9.9 billion in 1992 and nearly twelve billion dollars in 1995.[117]

The Economic Costs Relating to Alcohol and Drug Abuse

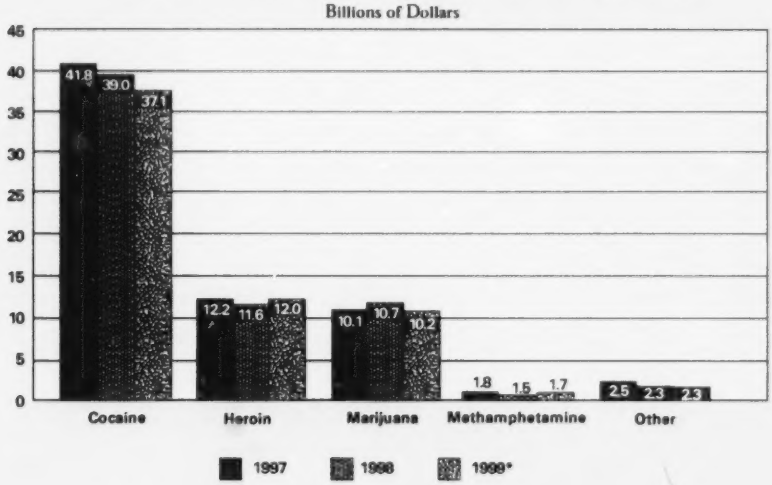


Economic Cost of Drug Abuse



Source: 1998 National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism

In 1999, Americans Spent $63.2 Billion on Illegal Drugs



**Projected figures from models based on 1998 data*
Source: 1999 ONDCP- What American Users Spend on Illegal Drugs

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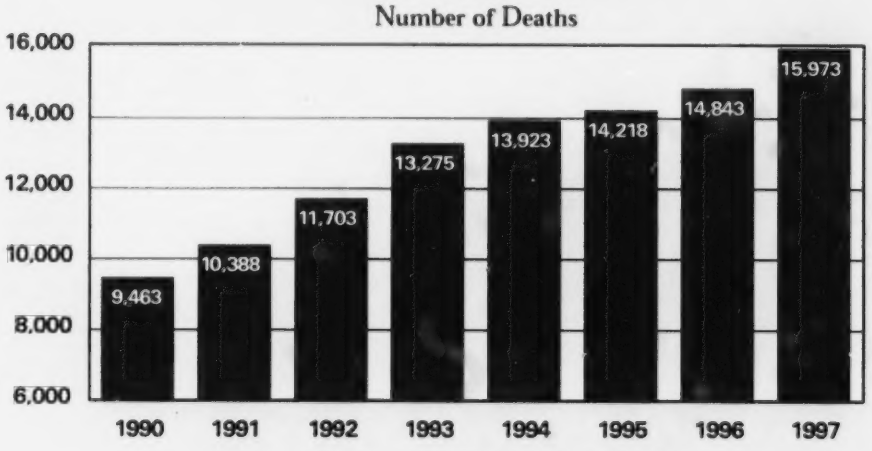
Drug-related deaths — Illegal drug use is responsible for the deaths of thousands of Americans annually. In 1997, the latest year for which death certificate data are published, there were 15,973 drug-induced deaths in America.[118] Drug induced deaths result directly from drug consumption, primarily overdose.* In addition, other causes of death, such as HIV/AIDS, are partially due to drug abuse. Using a methodology that incorporates deaths from other drug-related causes, ONDCP estimates that in 1995 there were 52,624 drug-related deaths. This figure includes 14,218 drug-induced deaths for that year, plus mortalities from drug-related causes.** SAMHSA's Drug Abuse Warning Network (DAWN) collects data on drug-related deaths from medical examiners in forty-one major metropolitan areas. DAWN found that drug-related deaths have steadily climbed throughout the 1990s.[119]

* Overdose deaths, including accidental and intentional drug poisoning, accounted for 90 percent of drug-induced mortalities in 1995. Other drug-induced causes of death involved drug psychoses, drug dependence, and nondependent use of drugs.

** Based on a review of the scientific literature, 32 percent of HIV/AIDS deaths were drug-related and included in the estimate of drug-related deaths. The following were also counted: 4.5 percent of deaths from tuberculosis, 30 percent of deaths from hepatitis B; 20 percent of deaths from hepatitis non-A/none-B; 14 percent of deaths from endocarditis; and 10 percent of deaths from motor vehicle accidents, suicide (other than by drug poisoning), homicide, and other deaths caused by injuries.

Drug-Induced Deaths



Source: 1999 Centers for Disease Control and Prevention

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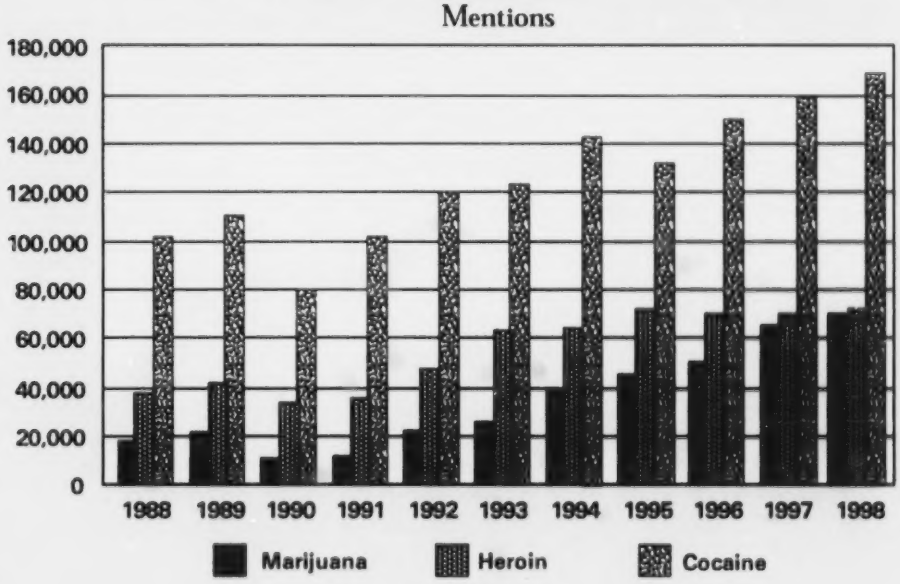
Drug-related medical emergencies — More than two thirds of people suffering from addiction see a primary-care or urgent-care physician every six months, and many others are seen regularly by medical specialists.[120] The DAWN survey provides information on the health consequences of drug use by capturing data on emergency department (ED) episodes that are related to the use of an illegal drug or the nonmedical use of a legal drug.* It is important to remember that DAWN data show only one dimension of the total consequences of drug use. It does not measure the prevalence of drug use in the population, the untreated health consequences of drug use, or the impact of drug use on health-care settings other than hospital EDs.

In 1998, there were an estimated 542,544 drug-related ED episodes and 982,856 ED drug mentions in the coterminous United States.[121] Nationally, the number of ED episodes and mentions remained relatively stable between 1997 and 1998. Among the drugs mentioned most frequently in ED reports, alcohol in combination with drugs (185,002), cocaine (172,014), and heroin/morphine (77,645) were statistically unchanged from 1997 to 1998 while marijuana/hashish mentions increased 19 percent (from 64,744 to 76,870). In drug-related ED episodes, overdose (245,164) was the most frequently cited reason for the drug-related ED visit; suicide (189,897) and dependence (189,094) were the most frequently cited motives for taking substances — both unchanged from 1997 to 1998.[122] Total drug related ED episodes were stable across gender, race/ethnicity, and most age subgroups, based on comparisons with 1997 and 1998. However, total episodes increased 9 percent (from 218,630 to 239,172) among patients aged thirty-five and older.[123]

* A drug episode is an emergency department visit that was related to the use of an illegal drug(s) or the nonmedical use of a legal drug for patients aged six years and older. A "drug mention" refers to a substance that was mentioned (as many as four) during a single drug-related episode.

Cocaine, Heroin, and Marijuana Hospital Emergency Room Mentions



Source: SAMHSA, 1998 DAWN Emergency Department Data

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Spreading of infectious diseases – Among the serious health and social issues related to drug abuse is the spread of infectious diseases. Drug abuse is a major vector for the transmission of AIDS and other sexually transmitted diseases, hepatitis, and tuberculosis – and for the infliction of violence.[124] Chronic users are particularly susceptible to infectious illnesses and are considered "core transmitters." Of the 18,361 cases of tuberculosis reported to the CDC in 1998, 2.9 percent were drug-related, down from 3.3 percent in 1997. There was a decline in drug-related AIDS cases between 1997 and 1998 among men from 33.3 percent in 1997 to 32.9 percent in 1998; among women, this number declined from 43.8 percent in 1997 to 42.3 percent in 1998.[125] Although no reliable estimate of the proportion of Hepatitis B cases that are drug-related is available, the number of Hepatitis B cases from 1996 to 1997 (the most recent year for which data are available) declined from 10,637 to 10,416.[126]

Homelessness – Drug abuse is a contributing factor in the problem of homelessness. Although only a minority (thirty-one percent) of the homeless suffer from drug abuse or alcoholism exclusively, inappropriate use of these substances compounds other diseases for many homeless people with mental illness who are "dually diagnosed."[127] Substance abusers with other illnesses experience homelessness of a longer duration and are more likely to be chronically without a residence.[128] Homelessness generates tremendous social and human costs. The general public is poorly served by having people with serious and chronic illnesses, such as addiction, living on the street. Further, addiction treatment tends to be less effective when recipients lack stable housing.[129] Of those who are currently homeless, twenty-five percent have ever been treated for drug abuse – thirty-six percent have received inpatient treatment and twenty-seven percent have received outpatient care.[130] Thirty-eight percent of those who are currently homeless have received inpatient treatment three or more times.[131] Homeless persons may be able to obtain residential treatment but with no recovery venue other than a shelter, such treatment is often ineffective.

Drug use in the workplace – According to the 1998 NHSDA, most drug users are employed. More than 73 percent of current illicit drug users aged 18 and older are employed full or part-time – more than 8.3 million workers.[132] Among full-time workers, aged 18-49, 7.7 percent were current illicit drug users in 1997 as were 9.3 percent of part-time workers.[133] In 1998 6.4 percent of full-time workers reported current illicit drug use as did 7.4 percent of part-time workers.[134] As national unemployment rates decreased, rates of drug use among the unemployed have risen. In 1998, 18.2 percent of unemployed adults aged 18 or older were current illicit drug users, compared to 13.8 percent in 1997.[135] In 1997, occupations with the highest drug-use rates, among full-time workers, aged 18-49, were food preparers, waiters/waitresses and bartenders (19 percent), construction (14 percent), other service occupations (13 percent), and material movers (10 percent).[136]

Drug use is estimated to cost fourteen billion dollars a year in decreased productivity.[137] In 1997, those who reported current illegal drug use were more likely than those who reported no drug use to have worked for three or more employers in the past year (9.3 percent versus 4.3 percent), to have skipped one or more days of work in the past month (12.9 percent versus 5 percent), or to have voluntarily left an employer in the past year (24.8 percent versus 15.4 percent).[138]

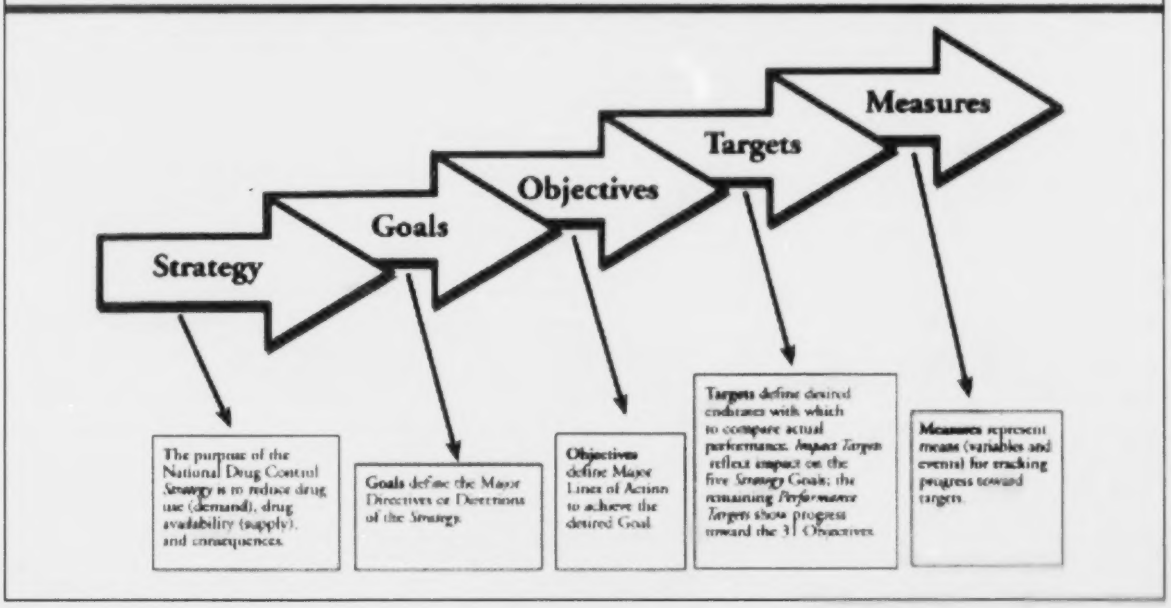
PERFORMANCE MEASURES OF EFFECTIVENESS (PME)

The stated intent of the *National Drug Control Strategy* is to reduce drug use and availability by 50 percent and decrease health and social consequences a minimum of 25 percent by 2007 (compared to 1996 baseline levels). The *Strategy* charts the course for accomplishing this end. Progress toward the *Strategy's* five goals and thirty-one objectives must be continuously assessed in order to gauge success or failure and adjust the *Strategy* accordingly. ONDCP has consulted with Congress, federal drug-control agencies, state and local officials, private citizens, and organizations with experience in demand and supply reduction to develop a Performance Measurement of Effectiveness (PME) system to gauge national drug-control efforts.

The PME system: (1) assesses the effectiveness of the *Strategy* and its supporting programs, (2) provides information to the entire drug-control community on what needs to be done to refine policy and programmatic directions, and (3) assists with drug-control budget management. The PME system fulfills congressional guidelines that the *National Drug Control Strategy* contain measurable objectives and specific targets to accomplish long-term quantifiable goals. These targets and annual reports are intended to inform congressional appropriations and authorizing committees as they restructure appropriations in support of the *Strategy* to ensure that resources necessary to attain ambitious long-term performance goals are provided.

The nucleus of the PME system consists of twelve "impact targets" that define measurable results to be achieved by the *Strategy's* five goals. There are five impact targets for demand reduction, five for supply reduction, and two for reducing the adverse health and criminal consequences associated with drug use and trafficking. Eighty-five additional targets further delineate mid- (2002) and long-term (2007) targets for the *Strategy's* thirty-one objectives. They are "stretch targets" in that they require progress above that attained in previous years. This system is in accordance with recommendations from the National Academy of Public Administration, the General Accounting Office, and other organizations advocating good government practices. The overall performance system is described in detail within a companion volume to this *Strategy* — *Performance Measures of Effectiveness: 2000 Report.*[138]

Performance Measurement Framework


Strategy
Goals
Objectives
Targets
Measures
The purpose of the National Drug Control Strategy is to reduce drug use (demand), drug availability (supply), and consequences.
Goals define the Major Directives or Directions of the Strategy.
Objectives define Major Lines of Action to achieve the desired Goal.
Targets define desired endstates with which to compare actual performance. Impact Targets reflect impact on the five Strategy Goals; the remaining Performance Targets show progress toward the 31 Objectives.
Measures represent means (variables and events) for tracking progress toward targets.

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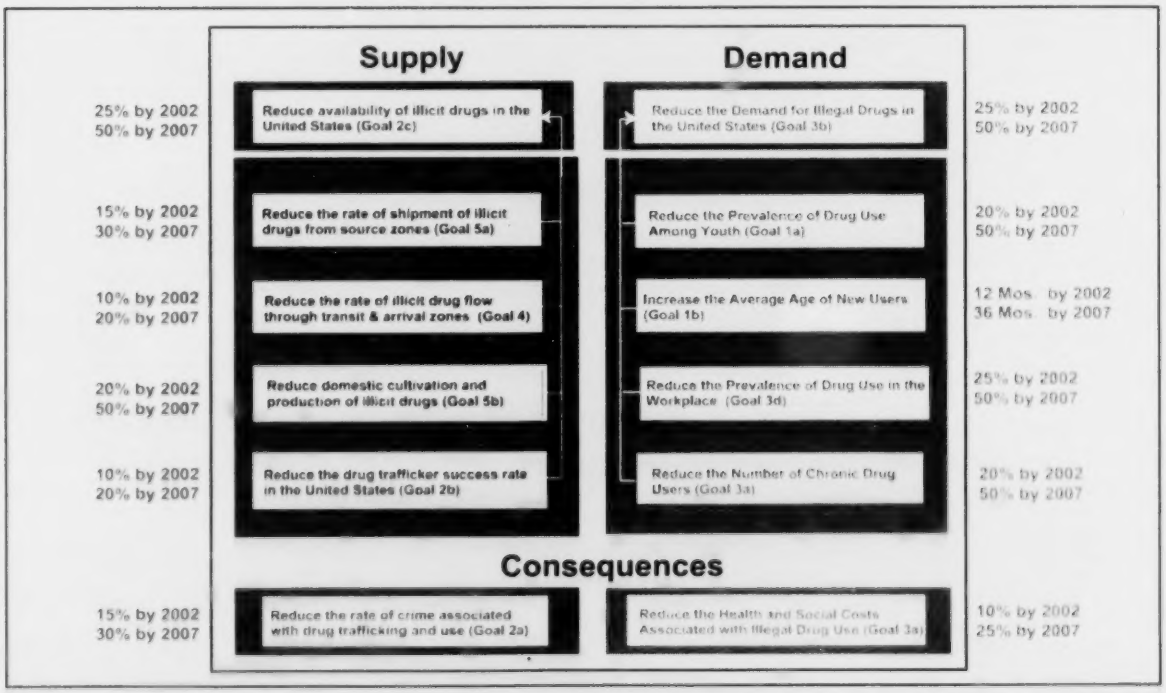
Progress toward each goal and objective is assessed using new and existing data sources. MTF and the NHSDA, for example, both estimate risk perception, rates of current use, age of initiation, and lifetime use for alcohol, tobacco, and most illegal drugs. The ADAM and DAWN surveys indirectly measure the consequences of drug abuse. The State Department's annual International Narcotics Control Strategy Report (INCSR) provides country-by-country assessments of initiatives and accomplishments. INCSR reviews statistics on drug cultivation, eradication, production, trafficking patterns, and seizure along with law-enforcement efforts including arrests and the destruction of drug laboratories. The Drug Control Research, Data, and Evaluation Committee (an advisory committee to the ONDCP Director), Subcommittee on Data, Research, and Interagency Coordination is developing additional instruments and measurement processes required to address the demographics of chronic users, domestic cannabis cultivation, drug availability, and other data shortfalls.*

The Fiscal Year 2001 *Budget Summary* (a companion volume to this *Annual Report*) associates federal drug-control budget requests with performance objectives. ONDCP's annual budget guidance to federal drug-control program agencies reflects the PME system's logic models and action plans. The federal government alone cannot attain the ambitious goals established by the PME system simply by altering its own spending and programs any more than the United States can unilaterally reduce cocaine production in South America or opium cultivation in Asia. A coalition of government, the private sector, communities, religious institutions, and individuals – a truly national effort – must embrace such a commitment for it to be successful.

* The Data Appendix to this Annual Report traces the reporting requirements outlined by Congress, the existing data instruments used to compile this 2000 report, areas where data is insufficient or infrequently collected, and steps being taken to remedy data inadequacies. Appendix H of *Performance Measures of Effectiveness: 2000 Report* outlines accomplishments in 1999 by ONDCP's Data Subcommittee that can help close the PME system data gap.


Supply
Demand
25% by 2002
50% by 2007
Reduce availability of illicit drugs in the United States (Goal 2c)
Reduce the Demand for Illegal Drugs in the United States (Goal 3b)
25% by 2002
50% by 2007
15% by 2002
30% by 2007
Reduce the rate of shipment of illicit drugs from source zones (Goal 5a)
Reduce the Prevalence of Drug Use Among Youth (Goal 1a)
20% by 2002
50% by 2007
10% by 2002
20% by 2007
Reduce the rate of illicit drug flow through transit & arrival zones (Goal 4)
Increase the Average Age of New Users (Goal 1b)
12 Mos. by 2002
36 Mos. by 2007
20% by 2002
50% by 2007
Reduce domestic cultivation and production of illicit drugs (Goal 5b)
Reduce the Prevalence of Drug Use in the Workplace (Goal 3d)
25% by 2002
50% by 2007
10% by 2002
20% by 2007
Reduce the drug trafficker success rate in the United States (Goal 2b)
Reduce the Number of Chronic Drug Users (Goal 3a)
20% by 2002
50% by 2007
Consequences
15% by 2002
30% by 2007
Reduce the rate of crime associated with drug trafficking and use (Goal 2a)
Reduce the Health and Social Costs Associated with Illegal Drug Use (Goal 3a)
10% by 2002
25% by 2007

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Endnotes

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III. Report on Programs and Initiatives

INITIATIVES TO PREVENT DRUG USE

Understanding what determines vulnerability to substance abuse is crucial to developing prevention programming. At this point, there is no evidence for a single, unique factor that determines which individuals will abuse drugs; rather, drug abuse appears to develop because of a variety of genetic, biological, emotional, cognitive, and social risk factors that interact with features of a social context. Thus, the combination of individual and social context factors appears to make someone more or less at risk for drug abuse and influence the progression from drug use to abuse to addiction.

NIDA-supported research has already identified many risk factors associated with the development of drug problems. These factors typically have been organized into categories that represent individual, familial, and social risks. For example, we now know that individual-level risks include shy, aggressive, and impulsive personality traits and poor academic achievement; family-level risks include poor parental monitoring and exposure to substance use by parents and siblings; school-level risk factors include a pro-drug use school norm and availability of drugs on or near the school campus; and community-level risks include lack of positive academic and recreational programming for children and adolescents during after-school and weekend hours and low levels of enforcement of laws pertaining to the use of licit and illicit substances by minors. This incomplete list illustrates the breadth and complexity of the risks that can confront any one person.

For many years, our focus was discovering the factors that put people, particularly children, at risk for drug use, abuse, and addiction. We discovered that there are protective or resiliency factors — factors that protect individuals from developing drug-related problems. NIDA-supported research has already uncovered many such protective factors that operate at the individual and contextual levels through the family, peer group, school, community, workplace, and the media, among others. Examples of protective or resiliency factors can include a stable temperament, a high degree of motivation, a strong parent-child bond, consistent parental supervision and discipline, bonding to prosocial institutions, association with peers who hold conventional attitudes, and consistent, community-wide anti-drug use messages and norms. An accumulation of protective factors may counteract the negative influences of a few risk factors. The challenge for the future is to understand how the accumulation of risk and protective factors interact to make individuals more or less vulnerable to trying drugs, to abusing drugs and/or becoming addicted to drugs. This knowledge will allow prevention researchers and providers to design programs that can be more effectively tailored to individual needs.

Researchers have developed and tested a variety of efficacious prevention programs, and have analyzed these programs to identify the fundamental principles of effective drug abuse prevention. These principles were published in 1997 in NIDA's *"Preventing Drug Use Among Children and Adolescents: A Research-Based Guide"*. As useful as these principles are, they are quite general, and must now be taken to a greater level of specificity. Prevention programs cannot simply be replicated in any setting. They must be responsive to the characteristics of different locales, and the needs of audiences that often vary in gender, ethnicity and age. We also need to determine how to best tailor programs to subpopulations that are at increased risk.

There is a need for research in several emerging areas of prevention. Strategies need to be developed that can help communities determine their needs and readiness for interventions. For example, communities require the epidemiological tools to assess their needs. Research is also needed to understanding the organization, management,

financing, and delivery of prevention services. In the treatment arena there are established systems such as clinics, hospitals, out-patient centers, HMOs, clinician training and certification systems. However, there are no defined prevention provisions, financing, training, or credentialing systems. It is therefore difficult to determine how decisions are made about prevention implementation. A fuller understanding of these issues will help integrate prevention strategies and programs into existing community level service delivery systems.

The Central Role of Parents

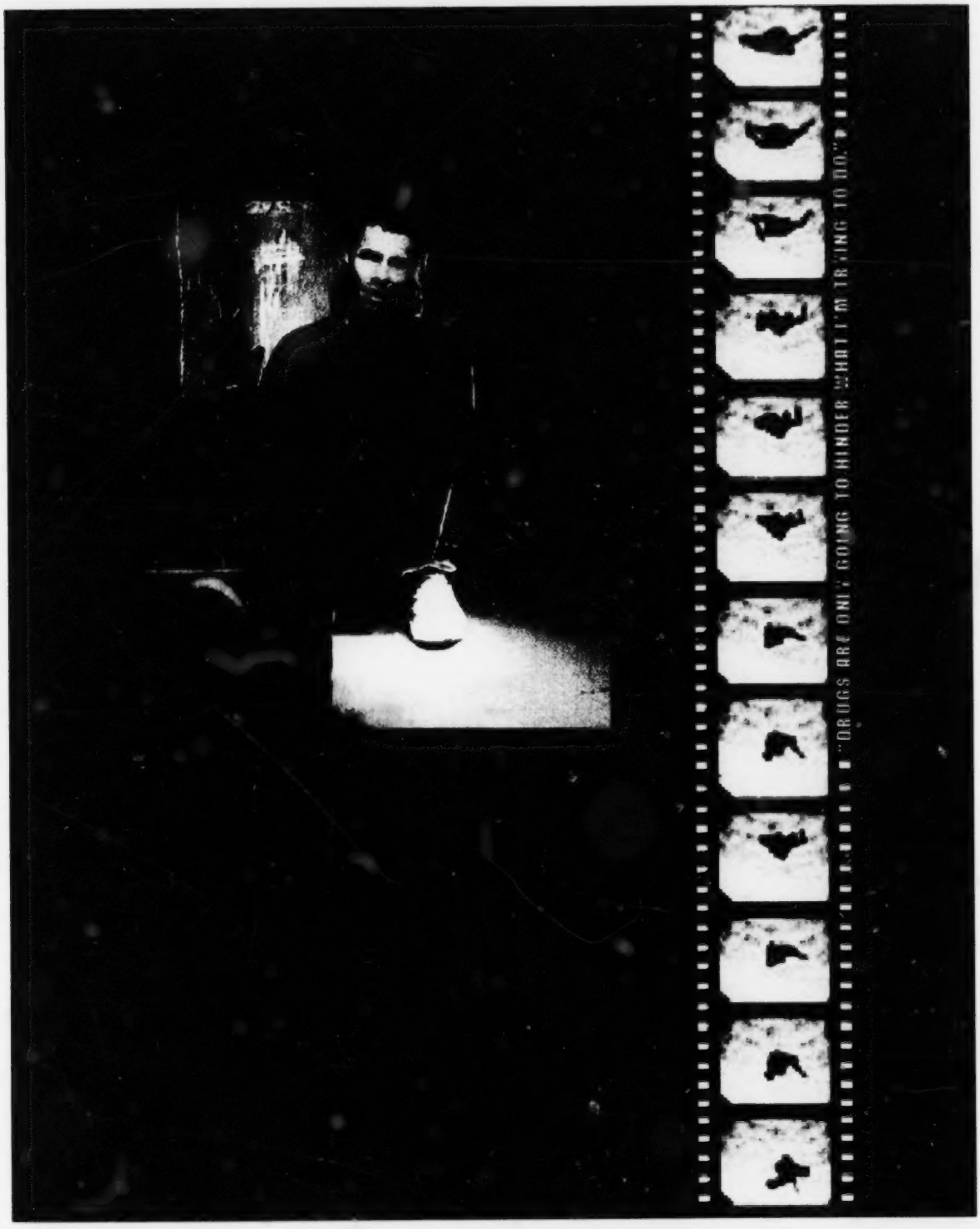
While all parents exert a critical influence on their children, mothers and fathers of eight to fourteen year olds are especially influential. Young people in this age group normally condemn drug use. Such attitudes and attendant behavior are easily reinforced by involved parents. Adults who wait until their children are older to guide their offspring away from drugs, allow peers to have more influence on their children's decision to use drugs.

SAMHSA/CSAP's High Risk Youth program has found that protective factors and family bonding drop dramatically between ages ten and fourteen. Based on such evidence, SAMHSA/CSAP has established a new Parenting and Family Strengthening program to increase the availability of family-based prevention interventions. This two-year program funded ninety-six cooperative agreements to increase local effective parenting and family programs, document the decision-making processes for selecting and testing interventions in community settings, and determine the impact of the interventions on target families. The program works to raise awareness of the fact that good parenting and strong families are key to preventing youth substance abuse. Through CSAP's Parenting *IS* Prevention Initiative, significant collaborative efforts have been made with major parenting organizations such as the Child Welfare League of America, Parents Without Partners International, The National Council on Family Relations, and the Head Start Association. As a result, these organizations are offering training and other resources to their members. Finally, SAMHSA/CSAP has launched a prevention program aimed at Spanish-speaking parents and grandparents called "Hablemos En Confianza."

Children whose parents abuse alcohol or illicit drugs face heightened risks of developing substance-abuse problems themselves. An estimated eleven million such children under age eighteen live in the United States. Every day, these young people receive conflicting and confusing messages about substance abuse. Nevertheless, specially crafted prevention interventions can break through the levels of denial inherent in these families. SAMHSA/CSAP's Children of Substance-Abusing Parents program is developing community-based interventions for these youth.

Substance-Abuse Prevention in Early Childhood

Early childhood is a perfect time for prevention that targets risk factors. Intervention for substance abuse is critically important during this time because it is from infancy to the preschool period when brain development is rapid and much more vulnerable to environmental influences.[1] Children who have not developed crucial intellectual, emotional, and social abilities by age three are more likely to have problems that can limit lifelong potential. Early risk factors include parental criminality and substance abuse, low verbal ability, social disorganization and violence in the neighborhood, poor family management practices, inconsistent or harsh parenting, low socioeconomic status, and exposure to media violence. Prevention works well at this early stage when children and caregivers are susceptible to learning. SAMHSA/CSAP has initiated several programs addressing prevention in early childhood. *Starting Early Starting Smart*, developed and conducted collaboratively with the Health Resources and Services Administration, the Administration for Children and Families, the U.S. Department of Education, the National Institutes of Health, and The Casey Family Program, is testing the effectiveness of integrating behavioral health services with primary care and/or early childhood service settings. SAMHSA/CSAP also sponsors a Predictor Variables investigational program which is seeking to develop further the knowledge about effective prevention interventions for young children (ages 3-14) by linking them with appropriate developmental stages. Since 1992, the Robert Wood Johnson Foundation has supported *Free to Grow: Head Start Partnerships to Promote Substance-Free Communities*. This program provides early childhood education, health, and social services to more than 750,000 low-income children in urban, suburban, and rural communities throughout the United States. The initiative addresses the problem of substance abuse by strengthening families and neighborhoods. *Free to Grow* supports the design and implementation of model substance-abuse prevention projects within local Head Start programs.



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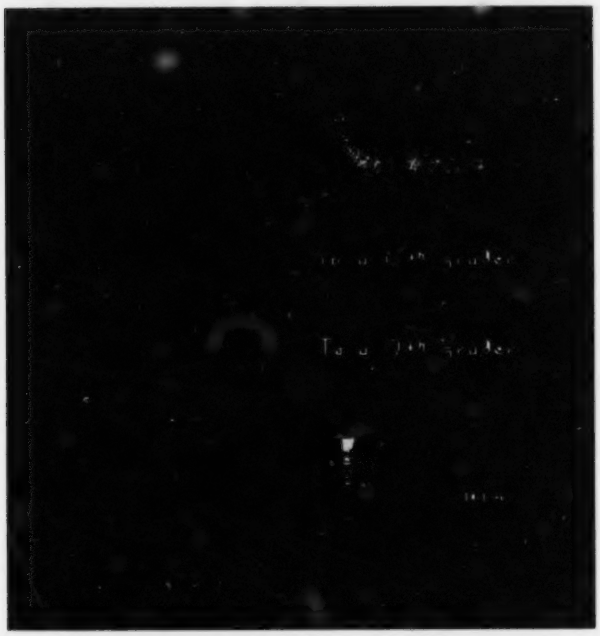

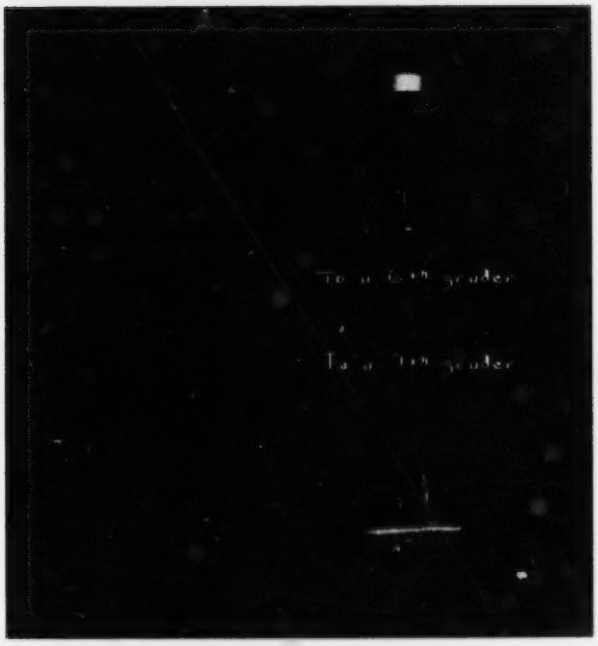

National Youth Anti-Drug Media Campaign

The goal of ONDCP's bipartisan five-year National Youth Anti-Drug Media Campaign is to harness the media to educate America's youth to reject illegal drugs. Advertising, television programming, movies, music, the Internet, and print media have a powerful influence on young people's view of drugs and other dangers. The campaign focuses on primary prevention — heading off drug use before it starts — for three reasons:

1. Primary prevention targets the underlying causes of drug use and therefore has the greatest chance of success.

2. Over time, primary prevention will reduce the need for drug treatment, which is in short supply.

3. A media campaign has more potential to affirm the anti-drug attitudes of youth who are not involved with drugs than to persuade regular drug users to give up drugs.

The media campaign is based on medical and behavioral research. The campaign was developed in consultation with scores of experts in behavioral science, medicine, drug prevention, teen marketing, advertising, communications, and representatives from professional, civic, and community-based organizations.

The media can play a critical role in public-health campaigns because of its educational ability to impart information and influence behavior. A carefully planned mass media campaign can reduce substance abuse by countering false perceptions that drug use is normal. In the past, media campaigns have proved successful in changing risky behaviors, such as driving under the influence of alcohol or without seat belts.[2] The media campaign needs to be integrated with anti-drug programs and other outreach initiatives based in homes, schools, places of worship and community-based organizations.

An integrated communications approach was instituted in 1999, at which time the Office of National Drug Control Policy focused on specific anti-drug themes and messages for advertising and other outreach efforts, to the entertainment industry, interactive media, and sports organizations.

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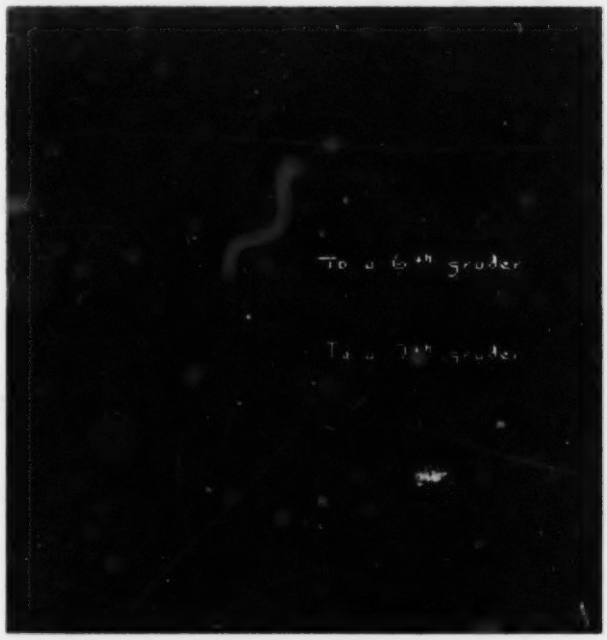
The advertising program is divided into four to six-week periods — a process called flighting — during which time a specific anti-drug message "platform" is communicated. Local coalitions and other partners can amplify these messages by adding their own messages and conducting related local events and activities.

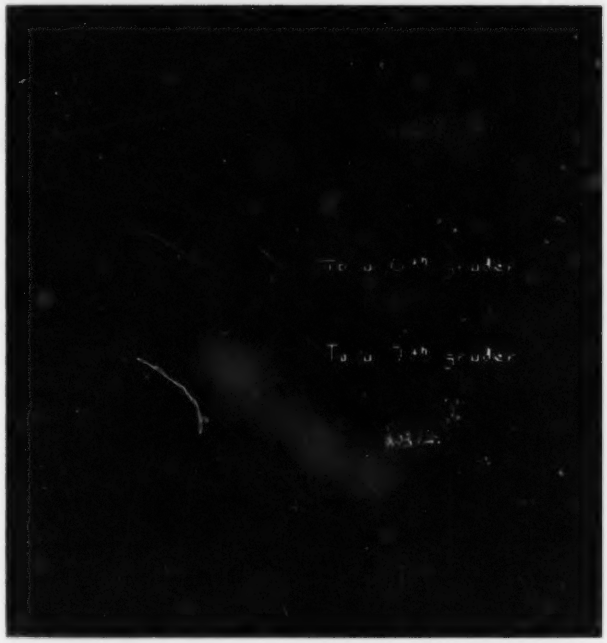
Matching contributions from media outlets also multiply the impact of these messages. When advertising is purchased from a media outlet, the outlet, as mandated by Congress, must match it dollar-for-dollar with a pro bono public service activity. Most matches involve time and space for public service announcements (PSAs); media outlets match a paid PSA with a second one of equal value in a similar time slot. Magazine inserts, program content, web site development, and community events also qualify for the pro bono match.

The Advertising Council and the American Advertising Federation lead efforts to choose eligible PSAs for both national and local media markets. Themes include underage alcohol use, parenting skills, mentoring, and structured activities for young people. In 1999 alone, the campaign shared more than 265,000 radio and television time slots with forty-five national organizations. To cite an analogy, "a rising tide floats all boats." Many related causes are served by the anti-drug media campaign.

The Partnership for a Drug-Free America (PDFA) is a private, non-profit, non-partisan coalition of professionals from the communications industry. Best known for its national, anti-drug advertising campaign, its mission is to reduce demand for illicit drugs in America through media communication. PDFA has generated more than $2.8 billion in media exposures and created more than five hundred anti-drug ads. Its long-standing national campaign is the single, largest, public service ad campaign in history. For twelve years, PDFA's process was the paradigm for a public service campaign. No other organization was as successful in generating high-quality free ads and placing them pro bono in the media.

PDFA is a key campaign partner. The Partnership had concluded that intense competition, brought on by the splintering of the media,





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brought new economic realities to the media industry in the 1990s. With media donations to the Partnership down by more than $100 million since 1991, the outlook for national media giving was uncertain. The ONDCP campaign promised something unprecedented for PDFA's public service advertising effort: precise placement of the right ads, targeting the right audience, running in the right media, consistently, over time. Presently, PDFA has developed 37 television commercials, 36 print ads, and 21 radio spots for parents and 37 TV commercials, 35 print ads, and 35 radio spots for youth.

In 1999 "branding" was introduced to unite parent message platforms, create synergy between advertising and non-advertising programs, and maximize campaign awareness and impact. The campaign's parent brand is "The Anti-Drug." It is a promise to provide America's youth and their parents with unequivocally honest and straightforward information — no hype, just honest, factual information. "The Anti-Drug" branding was launched in September 1999 in new advertising targeted at parents for television, radio, print, out of home media, and parenting brochures.

In 1999, the following organizations contributed to anti-drug efforts: the national Future Farmers of America (FFA), the YMCA of the USA and Youth Service America, National Association of State Alcohol and Drug Abuse Directors (NASADAD), Community Anti-Drug Coalitions (CADCA), the National Association of Children of Alcoholics, the National Middle School Association, the 21st Century Teachers Network, the National Elementary School Press Association, Cable in the Classroom, *The New York Times*, *Latina*, the Congress of National Black Churches, Global Mission Church, local churches and synagogues in various cities, Sun Microsystems, Media One, America Online, CSAP, NASA, and more than twenty federal agencies participating in the campaign's Federal Website Initiative.

The campaign developed Internet sites with industry giants like America Online (AOL). The Parents' Drug Resource Center — on AOL at Keyword "Drug Help" teaches parents about underage drug use, connects them to drug-help resources, and offers expert advice on child-rearing. In addition, content is being developed for campaign-related web sites. One site, Freevibe.com helps youngsters make positive, well-informed, life-style decisions. Other Internet initiatives combine online banner ads with educational mini-sites, online sponsorships, promotions and interactive events.

During the past year, the campaign reached 95 percent of America's youth at 8.3 times a week through advertising, and communicated advertising messages in eleven languages to youth and adults of various ethnic groups. The campaign represents the largest multicultural advertising and communications effort ever undertaken by the federal government, with messages and delivery tailored to ethnic audiences. It combines culturally competent and relevant messages designed by African American, Hispanic, and Asian-owned companies, to ensure the credibility of the messages and to enhance their impact.

In less than two years, the campaign's messages have become ubiquitous in the lives of America's youth and their parents. From network television advertisements to school-based educational materials, from youth basketball backboards to Internet web sites, and from local soccer competitions to national youth organizations, the campaign's messages reach Americans wherever they are — work, play, school, worship, and home.

Safe and Drug-Free Schools and Communities

The Department of Education's reauthorization proposal for the Safe and Drug-Free Schools and Communities Act (SDFSCA) aims to insure that every school in the United States will be free of illegal drugs, violence, and the unauthorized presence of firearms, tobacco, and alcohol. Guided by extensive input from SDFSCA program participants, evaluation studies, and program reviews, the reauthorization proposal requests significant changes that would promote improvements in programs funded under the SDFSCA. Two key changes include the following:

1. Emphasize the importance of research-based programs. States would competitively award subgrants to school districts and other applicants, largely in accordance with the quality of their plans. Consistent with the Principles of Effectiveness for the program, grantees would be required to implement research-based programs to address identified needs and established goals, and to assess progress regularly. The proposal would also increase support for state activities to help applicants create and implement effective, accountable programs.

2. Strengthen accountability. State and local recipients of SDFSCA funds would be required to adopt outcome-based performance indicators and report regularly on

their progress. Continuation of local grants would be conditioned upon achievement of satisfactory progress. School districts would also have to develop a comprehensive "Safe Schools Plan" to ensure that essential program components are in place and that efforts are coordinated with related community-based activities.

The reauthorization proposal reflects the direction the Department of Education's Safe and Drug-Free Schools Program is taking to ensure that SDFSCA fund recipients — including governors, state education agencies, local education agencies, institutions of higher education, and community organizations — adopt programs and practices that are based on research and evaluation. The proposal calls for a comprehensive approach that requires collaboration among agencies and organizations at the federal, state, and local level.

Key initiatives of the Safe and Drug-Free Schools Program (SDFSP) in 1999 have included Safe Schools /Healthy Students and the Middle School Drug Prevention and School Safety Program Coordinators. The former initiative, announced by the President in Spring 1999, is a grant competition jointly administered by the U.S. Departments of Education, Health, and Human Services, and Justice. The program promotes comprehensive, integrated community-wide strategies for school safety and health child development. These strategies provide students, schools, and communities enhanced educational, mental health, social service, law enforcement, and juvenile justice system services that can bolster healthy childhood development and prevent violence, alcohol, and drug abuse. Grants under this initiative have been awarded to fifty-four local educational agencies in partnership with local law enforcement and public mental health authorities. Annual awards range from three million dollars per year for urban school districts, two million dollars per year for suburban school districts, and one-and-a-half million dollars per year for rural and tribal school districts. A national evaluation of the Safe Schools/Healthy Students Initiative will be conducted to document the effectiveness of collaborative community efforts to promote safe schools and provide opportunities for healthy childhood development.

Under the Middle School Drug Prevention and School Safety Program Coordinators Initiative, ninety-seven school districts received $34.6 million in grants to recruit, train, and hire coordinators in middle schools. The three-year grants were awarded to school districts with significant drug, discipline, and violence problems in middle schools.

After-School Initiatives

Reducing the precursors of drug use — aggression, conduct disorders, shyness, and lack of school and family attachment — can be achieved through after-school activities. Mentoring programs increase the involvement of high risk youth with caring adults. Mentors help children by modeling, teaching, and reinforcing positive behavior. In FY 1999, the Departments of Justice and Education collaborated to support twelve grants providing one-to-one mentoring programs for youth at risk of educational failure, dropping out of school, or involvement in delinquent activities including gangs and drug use. SAMHSA/CSAP'S Project Youth Connect is evaluating the comparative benefits of youth-only approaches versus programs that involve parent AND youth mentors. CSAP's public education campaign, Your Time — Their Future, encourages adults to get involved with youth to help young people build skills, self-discipline, and competence to resist alcohol, tobacco, and illicit drugs.

Drug-Free Communities

Government response is only a small part of the national effort to counter illegal drugs. Communities are significant partners for local, state and federal agencies working to reduce drug use, especially among young people and deserve continued support. Local coalitions, comprised of a broad sector of community leadership, are working to devise sound strategies based on local data and knowledge of a growing body of scientifically supported program ideas. Local leaders know that they must sustain their efforts into the foreseeable future if we are to significantly reduce demand for illegal drugs at the community level.

The Drug-Free Communities Program, created through the Drug-Free Communities Act of 1997, provides funds, knowledge, and other resources to help local leaders prevent youthful drug problems, including the underage use of alcohol, tobacco, and inhalants. This program now supports 213 communities located in forty-five states, Puerto Rico, and the U.S. Virgin Islands. Applicant communities must match their grant awards with funding from non-federal sources. Communities may reapply for federal funds over an additional four years, but after year two become eligible for decreasing levels of federal support. The intent of Congress is to support programs that are able to support themselves in the future through non-federal resources.

CSAP carries out training and technical assistance to grantee communities through a network of private sector collaborators. The regional Centers for the Application of Prevention Technologies (CAPT) offices offer high quality, research-based knowledge and information to state and community prevention programs. Several major information clearinghouses, including the CSAP-sponsored National Clearinghouse for Alcohol and Drug Information (NCADI) provide free or low-cost material directly to all U.S. communities.[3]

In December 1999, SAMHSA announced the results of an extensive study of community anti-drug partnerships. Statistically significant reductions in drug and alcohol use were found among males in communities with such programs.[4] A core set of desirable strategies that can be used by other communities were identified among model community partnerships identified in this study. These include a comprehensive vision, a wide sharing of this vision, avoidance or resolution of severe conflict in the partnership, non-disruptive partnership staff turnover, a strong core of committed partners, an inclusive and broad-based membership, decentralized management and extensive and diverse prevention activities.

The Drug-Free Communities Program is complemented by a number of private sector organizations and other public agencies, including the National Association of State Alcohol and Drug Abuse Directors (NASADAD), National Prevention Network, National Guard, Mothers Against Drunk Driving (M.A.D.D.), AmeriCorp, and National Inhalant Prevention Coalition, that provide useful tools, occasional funding and frequent communications among the communities and other useful resources. The program is ably guided by the Advisory Commission on Drug-Free Communities, an eleven member, presidentially-appointed expert group representing many sectors and organizations across the United States. The Community Anti-Drug Coalitions of America (CADCA) is a coalition membership organization that provides a wide array of technical support, program ideas, and advocacy to community coalitions around the U.S. CADCA (www.cadca.org) actively assists the Drug-Free Community grantees on a regular basis. Join Together, a Boston University based organization, (www.jointogether.org) examines and reports on critical issues of interest to communities around the issues of drugs, guns, and violence.

At the national level, future initiatives will involve creating new training capabilities, detailed descriptions of successful local innovations that can be replicated through public/private coalitions, and better dissemination and utilization of scientific knowledge about the application of prevention strategies in the natural environments of neighborhoods and communities. In addition, efforts on the local level should be focused on improved data collection and analysis which can inform coalition leadership, so that they may make educated financial and personnel decisions in the best interest of the coalitions.

Housing Initiatives

Housing and Urban Development's (HUD) Public and Indian Housing Drug Elimination Program provides funds to public housing agencies, Indian tribes and their tribally designated housing entities, and owners of federally assisted low-income housing to support their anti-drug and anti-crime efforts. Since 1989 HUD awarded approximately 6,500 grants totaling more than $2 billion to public housing agencies and tribally designated housing entities. Grantees have used these resources to fight crime by increasing police coverage and security and by providing residents with alternatives to crime and violence. In particular, they have used their PHDEP funding to employ security personnel and investigators; to contract with private security services; to reimburse local law enforcement agencies for above-baseline services; to establish volunteer resident patrols; to implement physical improvements to enhance security; and to establish and operate drug prevention, intervention, and treatment programs, as well as youth violence prevention initiatives.

Prevention through Service Alliance

Volunteer based organizations continue to make major contributions to the national counter-drug effort. Since November 1997, an alliance of civic, fraternal, service, veterans, sports, and women's groups has been helping young people pursue healthy, drug-free lifestyles. Currently, national service organizations representing more than a hundred million volunteers are members of a "Prevention Through Service Alliance."* Through a resolution agreement, member organizations have pledged to increase substance-abuse prevention messages to their members and the youth they serve, establish a communication link to share programs and resources, collaborate on community prevention efforts, promote service opportunities for youth, and publicly recognize young people involved in community service. Alliance organizations offer mentoring programs, school-based curricula dealing with drug prevention, and educational brochures for youth. Other Alliance-supported activities that promote a drug-free lifestyle include youth groups, sports teams, scholarships, and specific drug-free events. Many Alliance groups have assisted in the ONDCP National Youth Anti-Drug Media Campaign. During this coming year, a significant number of Alliance partner organizations will provide pro-bono contributions to the media campaign through their national publications and web sites.

Workplace Prevention Initiatives

The workplace is an effective venue for influencing drug use behavior and shaping community norms for drug-free living. In 1998, more than 73 percent of all current drug users were employed full or part-time – more than 8.3 million workers.[6] About 1.6 million full-time workers, aged 18-49, both abuse illicit drugs and are heavy alcohol users.[7] Alcoholism alone accounts for 500 million lost workdays each year.[8] Casual drinkers, in aggregate, account for far more incidents of absenteeism, tardiness, and poor quality of work than those regarded as alcohol dependent.[9] Among 18-49 year-olds, the highest rate of illicit drug abuse and heavy alcohol use is among those 18-25 years old, males, whites, and those with less than a high school education.[10] About one half of young adults ages 16-17, work during the year. Those working more than 20 hours per week are at high risk for substance abuse and injury.[11]

Since 1986, Executive Order 12564,the Drug-Free Federal Workplace, has mandated a comprehensive drug-free workplace program for all Executive Branch federal agencies. Elements include a clear policy of no use; employee education about the dangers of illicit drug use and the workplace consequences of drug use; supervisor training about their responsibilities under the policy; access to employee assistance programs (EAPs) and treatment referral; and accurate and reliable drug testing, consistent with the policy. These programs have been implemented in 120 federal agencies, with 1.8 million employees, and the Mandatory Guidelines for Federal Workplace Drug-Testing Programs have also been adopted by the Department of Transportation and the Nuclear Regulatory Commission for their regulated industries. As the nation's largest employer, the federal government has continued to provide leadership by example. For federal job applicants and employees, the positive rate is one-tenth of the national average, or only 0.5 percent, compared to 5.0 percent for other workplaces nationally.[12]

The available data suggest that comprehensive drug-free workplace programs also work for non-federal public and private sector employers. Periodic surveys of employees in large workplaces (500 or more employees) say such organizations are more likely to incorporate drug-free workplace policies, information, access to EAPs, and drug testing, than smaller employers (1-24).[13] Perhaps even more important for all employers to consider is that current illicit drug users say they would be less likely to work for an employer that conducted pre-employment or random drug testing.[14] Prevention in the workplace helps non-users from starting and users from increasing their dependence on

* Current Alliance member organizations are 100 Black Men of America, Inc., AMBUCS, AMVETS, Benevolent and Protective Order of Elks, Big Brothers Big Sisters, Boys and Girls Clubs of America, Boy Scouts of America, B'nai B'rith Youth Organization, Camp Fire Boys and Girls, Campus Outreach Opportunity League, Civitan International, Fraternal Order of Eagles, General Federation of Women's Clubs, Girls, Inc., Girl Scouts of the USA, Improved Benevolent and Protective Order of Elks of the World, Independent Order of Odd Fellows, Jack and Jill of America, Inc., Junior Chamber International, Knights of Columbus, Lions Clubs International, Moose International, Masonic National Foundation for Children, Mothers Against Drunk Driving, National Beta Club, National Council of Negro Women, National Council of Youth Sports, National Exchange Club, National Family Partnership, National 4-H Council, National FFA Organization, National Panhellenic Conference, National Retired Teacher's Association, Optimist International, Pilot International, Quota International, United Native Tribal Youth, Ruritan National, Sertoma International, The Links, Inc., Veteran's of Foreign Wars, YMCA of the USA, Youth Power, Youth to Youth International, YWCA of the USA, and Zeta Phi Beta Sorority, Inc.

illegal drugs and alcohol.[15] Workplaces provide an ideal opportunity to influence individual behavior and community norms. Clear and consistent messages of no use and the consequences of use are crucial. Referrals to treatment and support for employees who want to change their behavior are key. EAPs offer a wide range of services and are increasingly being used by employers.

Implemented in the interest of public safety and expanded under the Omnibus Transportation Employee Testing Act of 1991, the Department of Transportation's (DOT) mandatory drug-free workforce initiative has helped reduce drug abuse in the transportation industry. This program has become the industry model for non-regulated employers throughout the United States and other countries around the world. DOT's program, covering eight million individuals, encompasses more than just drug testing; it is built around employee education, supervisory training, and rehabilitation for workers in regulated businesses within the aviation, motor carrier (including drivers from Canada and Mexico), rail, transit, pipeline, and maritime industries. DOT requires workers in safety-sensitive positions who test positive for drugs to be referred to substance-abuse professionals before returning to work. If substance abuse is diagnosed, the employee must receive treatment before resuming duties. The level of positive drug test results in transportation has dropped approximately fifty percent since the program's onset.

Adoption of anti-drug programs in the private sector, most notably by employers with worksites of more than five hundred employees, has produced a two-thirds reduction in the rate of positive drug test results in the last decade – from 13.6 percent in 1988 to 4.7 percent in 1999.[16] Within a comprehensive approach, drug testing has proven to be an effective tool not only to identify drug use before serious harm or accidents develop but as a way to cut through the denial of many drug users, which frequently impedes their ability to seek treatment. According to a study by the American Management Association of its membership's (typically larger employers) corporate practices, workplace drug testing increased from 1987 to 1996 by 1200 percent. Likewise, the perceived effectiveness of drug testing increased from 50 percent to 90 percent in 1996. Companies combining testing with other anti-drug initiatives report test positive rates 33 percent to 50 percent lower than companies that conduct drug tests only.[17]

However, 80 percent of private-sector U.S. workers are employed in small or medium-sized organizations which have a significantly lower percentage of drug-free workplace programs. Considerable challenges remain for these businesses to emulate the reduction in work-related accidents, absenteeism, health care expenses, and worker compensation costs reported by larger employers implementing drug free programs. To help address this need among smaller employers, Congress passed the Drug-Free Workplace Act of 1998, funding thirty new grants and contracts through the Small Business Administration's new Drug-Free Workplace Demonstration Program. SAMHSA/CSAP also assists businesses implement drug-free workplace programs through its website (www.health.org/workpl.htm), Workplace Helpline,[19] and by providing supplemental materials and training programs on request.[19] Additionally, businesses and other employers can access the Department of Labor's (DOL) Working Partners for an Alcohol- and Drug-Free Workplace initiative and website (www.dol.gov/dol/workingpartners.htm).[20]

Athletic Initiative

Each year approximately 2.5 million students play football and basketball in high school and junior high. Millions of children are involved in soccer and softball leagues, among other sports. Studies show that a young person involved in sports is 40 percent less likely to get involved with drugs than an uninvolved peer.[21] Scores of children admire professional athletes, but some stars often convey mixed messages pertaining to drugs.

In 1998, ONDCP began an Athletic Initiative Against Drugs.[22] During 1999, ONDCP provided coaches across the nation with the *Coach's Playbook Against Drugs*, which contains information to help prevent drug abuse among their students and teams.[23] ONDCP/CTAC is sponsoring a comprehensive analysis of the use of banned substances and drugs of abuse among Olympic, professional, collegiate, and high school athletes in America to identify more effective substance-abuse testing, sanctions, and treatment. ONDCP joined a wide range of athletes and teams from the victorious U.S. Women's World Cup soccer team to the New York Rangers and Knicks – to convey anti-drug messages to America's youth. In 2000, we will conduct regional soccer tournaments.

The use of drugs in sports has become a serious threat – not just to elite athletes but also in colleges and high schools across America. To help address this problem, ONDCP, the Department of Health and Human Services, and the White House Olympic Task Force have been working together on

behalf of young athletes. As part of this effort, ONDCP is assisting the U.S. Olympic Committee form an independent agency to oversee amateur athletic drug-testing in the United States. Internationally, the United States joined the twenty-six nations assembled at the Sydney, Australia Summit on Drug Use in Sport to develop an international agreement on combating this threat.

Faith Initiative

The faith community plays a vital role in building social values, informing the actions of individuals and inculcating life skills that are critical to resisting illegal drugs. The clergy of faith-based organizations serve as civic leaders. Many run programs that provide much-needed counseling and drug treatment for members of their communities. Consequently, ONDCP encourages religious communities to speak out against drugs and further develop faith-based initiatives to prevent and treat drug use.

Drug Prevention through Law Enforcement

Many federal agencies form government partnerships to prevent drug abuse. DEA's Demand-Reduction Program supports youth-oriented drug prevention through educational activities like the Boys Scouts of America's Law Enforcement Explorer Program. The FBI's Community Outreach disseminates prevention material and sponsors youth programs like Adopt-A-School and Junior Special Agent Classrooms. The Bureau of Justice Assistance (BJA) helped revise the Drug Abuse Resistance Education (D.A.R.E.) curriculum. D.A.R.E. is an extremely popular program for school-based drug abuse and violence prevention. It is being implemented by more than 8,600 law-enforcement agencies. The ATF's Gang Reduction Education and Training (GREAT) program helps teach seventh graders to reject gangs and the drugs often associated with them. The United States Customs Service actively supports the Explorer program, maintaining 37 posts that provide young adults with drug abuse prevention training for dissemination to the community. The Office of Juvenile Justice and Delinquency Prevention (OJJDP) runs a life-skills training program that provides curriculum, training, and technical assistance at seventy demonstration sites. The National Citizens' Crime Prevention Campaign focuses on reducing juvenile crime and drug use. The Office of Justice Programs supports projects related to juvenile substance abuse, like Combating Underage Drinking and the Juvenile Mentoring program. All Weed and Seed sites are required to have "Safe Havens" – after-school programs where anti-drug education joins a range of constructive activities. The DOJ Drug Education for Youth (DEFY) program promotes positive life choices, including drug resistance, in nine-to-twelve year-olds. DEFY's two-phased curriculum covers summer leadership camp coupled with a school-year mentoring program.

Countering Attempts to Legalize Drugs

Given the negative impact of drugs on society, the overwhelming majority of Americans reject illegal drug use. Indeed, millions of citizens who once used drugs have turned their backs on such self-destructive behavior. While most people remain steadfast in condemning drugs, small elements at either end of the political spectrum argue that prohibition – not drug abuse – creates problems. These groups offer solutions in various guises, but one of the most troublesome is the notion that eliminating the prohibition against dangerous drugs would reduce the harm drugs cause. Such legalization proposals are often presented under the euphemism of "harm reduction."

All drug policies claim to reduce harm. No reasonable person advocates a position consciously designed to be harmful. The real challenge is to determine which policies *actually* decrease harm and increase good. The approach chosen by some people who say they favor "harm reduction" – when they are really supporting drug legalization – would in fact hurt Americans.

The theory behind what legalization advocates call "harm reduction" is that illegal drugs cannot be controlled by law enforcement, education, public-health interventions, and other methods. Therefore, proponents say, harm should be reduced by the decriminalization of drugs, heroin maintenance, and other intermediate measures. The real intent of many harm-reduction supporters is the legalization of drugs, which would be a mistake.

Some people maintain that they are not calling for the legalization of all drugs but only "soft" drugs. Since many users enter treatment every year to help recover from chronic abuse of marijuana and other "soft" drugs, this idea overlooks the danger posed by such substances. Groups that support decriminalization of drugs, so that drug use would remain against the law but penalties would be minimal, want use of illegal drugs to resemble minor indiscretions like jay-walking. Other defenders

emphasize the therapeutic value of specific drugs or economic viability of drug-related products. By making drug use more acceptable, these people argue, society would reduce the harm associated with drug abuse.

The truth is that drug abuse wrecks lives. It is shameful that more money is spent on illegal drugs than on art or higher education, that drug-exposed babies are born addicted and in pain, that thousands of adolescents lose their health and future to drugs. Addictive drugs were criminalized because they are harmful; they are not harmful because they were criminalized. If drugs were legalized in the U.S., the cost to the individual and society would grow astronomically.

The Use of Marijuana as Medicine

Because of its high potential for abuse and lack of accepted medical use, the manufacture, acquisition, distribution, and possession or marijuana is subject to regulation under Schedule I of the Controlled Substances Act, the most restrictive of the five federal classes of controlled substances. The medical use of Schedule II, drugs such as cocaine and methamphetamine, is also strictly controlled. Marijuana is regulated internationally by the Single Convention on Narcotic Drugs, to which the United States is a party. In the past decade, data has been gathered relative to the negative impact of marijuana on young people. As described in Chapter II, marijuana use by adolescents correlates with delinquent and antisocial behavior.

The Administration is adamantly opposed to the use of marijuana outside of authorized research.[24] However, legitimate medications containing marijuana components have proven effective in relieving the symptoms of some medical conditions. Dronabinol, a synthetic form of the major psychoactive component in marijuana — tetrahydrocannabinol (THC) — has been approved by the Food and Drug Administration (FDA) to stimulate appetite in AIDS patients and to control nausea in cancer patients receiving chemotherapy. The pill form of THC has been available for fifteen years and sold under the trade name Marinol.® Dronabinol was rescheduled in 1999 to Schedule III of the Controlled Substances Act, making it easier for patients to obtain.

The Administration has provided information to states considering ballot initiatives on "medical marijuana" so that citizens will be informed about the ways such measures undermine the scientific process for establishing safe and effective medicines. These initiatives also contradict federal law and are potential vehicles for the legalization of recreational marijuana use. Ballot initiatives to date generally have not limited use of marijuana to a small number of terminally-ill patients, as most voters envisioned. Rather, they commonly allow marijuana to be obtained without prescription and used indefinitely without evaluation by a physician.

The U.S. medical and scientific communities have not closed the door on marijuana or any other substance that may offer therapeutic benefits. However, both law and common sense dictate that the process for establishing substances as medicine be thorough and science-based. Persons who intend to study or seek approval of marijuana for use in the cure, mitigation, treatment, or prevention of disease are subject to the "drug" and "new drug" provisions of the Federal Food, Drug, and Cosmetic Act (FDC Act) (21 USC 321 et seq.). The FDC Act requires an applicant to submit data from well-controlled clinical trials to the FDA for evaluation of the safety and efficacy of a proposed product. A New Drug Application (NDA) must contain sufficient information to satisfy the statutory standards for marketing approval. This rigorous process is in the interest of public health. Allowing marijuana, or any other drug, to bypass this process would be unwise and unlawful.

In light of the need for research-based evidence, ONDCP asked the Institute of Medicine (IOM) in January 1997 to review all scientific evidence concerning the medical use of marijuana and its constituent cannabinoids. ONDCP felt that an objective, independent evaluation of such research was appropriate given the ongoing debate about the health effects of cannabis. The IOM published *Marijuana and Medicine: Assessing the Science Base* in March 1999.[25] This study is the most comprehensive summary of what is known about marijuana. It emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous analysis) as opposed to belief-based opinion (derived from judgment or intuition untested by science).

The IOM study concluded that there is little future in smoked marijuana as medication. Although marijuana smoke delivers THC and other cannabinoids to the body, it also contains harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for pregnant women and patients with chronic diseases. In addition, cannabis contains a variable mixture of biologically active compounds. Even in cases where marijuana can

provide symptomatic relief, the crude plant does not meet the modern expectation that medicines be of known quality and composition. Nor can smoked marijuana guarantee precise dosage. If there is any future for cannabinoid medications, it lies with agents of certain composition and delivery systems that permit controlled doses. Medical marijuana must conform to classical pharmacological practices that characterize clinical research.

The United Nations' International Narcotics Control Board (INCB), which ensures an adequate world supply of drugs for medical purposes, has stressed that research must not become a pretext for legalizing cannabis. If the drug is determined to have medicinal value, the INCB maintains that its use needs to be subjected to the same stringent controls applied to cocaine and morphine. "Should the medical usefulness of cannabis be established," the 1998 INCB annual report states, "it will be a drug no different from most narcotic drugs and psychotropic substances. Those drugs, however, must continue to be used for medical purposes only, in line with the requirements of the international drug control treaties."[26] The INCB report concluded: "Political initiatives and public votes can easily be misused by groups promoting the legalization of all use of cannabis for recreational use under the guise of medical dispensation."[27]

"Industrial" Hemp

Under the Controlled Substances Act, the definition of marijuana includes all parts of the Cannabis sativa plant except for the sterilized seeds, fiber from stalks, and oil or cake made from the seeds.[28] However, all hemp products that contain any quantity of THC are considered Schedule I controlled substances and cannot be imported into the United States or cultivated domestically without DEA registration and permits.

Hemp products — fiber for use in the manufacture of cloth, paper, and other products as well as seed for birdseed — were authorized for importation during the last decade. Over the past two years, the Drug Enforcement Administration (DEA) received information that sterilized cannabis seed, not solely birdseed, has been imported for the manufacture of products intended for human consumption. DEA also learned from the armed forces and other federal agencies that individuals who tested positive for marijuana use subsequently raised their consumption of these products as a defense against positive drug tests. Consequently, the Administration is reviewing the importation of cannabis seeds and oil because of their THC content. NIDA is studying the effect of ingesting hemp products on urinalyses and other drug tests.

The government is concerned that hemp cultivation may be a stalking horse for the legalization of marijuana. According to a recent report by the Department of Agriculture, U.S. markets for hemp fiber (specialty textiles, paper, and composites) and seed (in food or crushed for oil) are, and will likely remain, small and thin.[29] U.S. imports of hemp fiber, yarn, and fabric and seed in 1999 could have been produced on less than 5,000 acres of land. Also, the potential exists for these markets to quickly become oversupplied. Uncertainty about long-run demand for hemp products and the potential for oversupply discounts the prospects for hemp as an economically viable alternative crop for American farmers.

Child Welfare Initiatives

The safety of children and families is jeopardized by the strong correlation between chemical dependency and child abuse. Several studies recently demonstrated that approximately two-thirds of more than 500,000 children in foster care have parents with substance-abuse problems.[30] A new federal law regarding adoption and child welfare, the Adoption and Safe Families Act (P.L. 105-89), requires that substance-abuse services be provided promptly for parents so that families are given realistic opportunities to recover from drug problems before children in foster care are placed for adoption.

In addition to compromising parental ability to raise children, substance abuse interferes with the acquisition and maintenance of employment. An estimated 15 to 20 percent of adults receiving welfare have substance-abuse problems that prevent them from working.[31] If drug prevention and treatment are not provided for this high-risk population, these families will remain extensively involved in the welfare and criminal-justice systems at great cost to society and with devastating consequences for children. Historically, welfare agencies have not played a direct role in addressing substance abuse and therefore may need assistance in identifying addiction and making appropriate referrals.

To address these issues, SAMHSA/CSAP's Parenting Adolescents and Welfare Reform Program focuses on the parenting adolescent (who often must rely on welfare) to prevent or reduce alcohol, tobacco, and drug use;

improve academic performance; reduce subsequent pregnancies; and foster improvement in parenting, life skills, and general well-being. The Administration for Children and Families (ACF) has taken several steps to improve the delivery of substance abuse services to clients involved with child protection and welfare programs. Five states are implementing child welfare waiver demonstrations that test strategies to engage and retain clients in substance abuse treatment. Conferences and technical assistance workshops have been held around the nation, in cooperation with SAMHSA, to encourage improved partnerships between human services and substance abuse agencies and to highlight model programs. In addition, grants have been made to several schools of social work to develop cross training curricula in these fields. Finally, research is being conducted on how to screen and assess substance abuse and other barriers to work and to evaluate a model of addressing clients' substance abuse problems.

Welfare-to-Work Initiatives

Although states have experienced remarkable success in decreasing welfare rolls, many of those who remain on welfare suffer from alcohol or drug addiction, which impedes their ability to succeed in the workplace. The federal government is looking for ways to help welfare and workforce agencies identify and refer welfare recipients and other underemployed individuals — whose employability is hindered by substance abuse problems — to treatment. To help these individuals make a successful transition to meaningful employment, DOL, through the Workforce Investment Act of 1998, supplies funds to states and communities to help deliver substance abuse services to the unemployed. Through Welfare-to-Work grants, a total of 138 million dollars has been awarded to provide workforce preparation and job retention services that include substance abuse programs and are available to eligible long-term welfare recipients and non-custodial parents. Of these grants, thirteen, totaling fifty million dollars, specifically target substance abuse services.

In FY 1999, Congress authorized $24 billion for states to spend on children's health services, to provide a safety net for children with substance abuse problems, whose parents are off welfare either because they have found jobs or have been taken off welfare. Subsequently at least nine have developed plans that specifically include substance-abuse services. Alabama, for instance, will provide specialty care to uninsured children and those with special needs. Delaware's Children's Health Insurance Program (CHIP) includes 31 days of substance abuse and mental health treatment services annually, plus outpatient mental-health care. Florida's health care and children's agencies will provide Medicaid and state-funded addiction and mental-health services, while the state mental-health agency will work with at risk youth in the criminal justice system.

The Partners Project in Pittsburgh, Pennsylvania, funded by a one million dollar grant from the Department of Housing and Urban Development, provides comprehensive services to welfare recipients, and their children, in recovery from substance abuse problems. This project offers specialized addiction treatment and other services to families living in 22 subsidized apartments. In addition to the Housing Authority of the City of Pittsburgh, a treatment program, child development center at the University of Pittsburgh Medical Center, and a local women's center for victims of domestic violence are part of the project.

Youth Tobacco Initiative

The Youth Tobacco Initiative is a multifaceted HHS campaign coordinated by the Centers for Disease Control and Prevention (CDC). Its purpose is to reduce availability and access to tobacco and the appeal tobacco products have for youth. The initiative includes funding for tobacco prevention and cessation programs, research, legislative projects, regulation, and enforcement. It is supported by the FDA, NIH, and SAMHSA. The FDA — under the Food, Drug and Cosmetics Act — regulates and enforces federal age and identification requirements regarding the sale of tobacco products. The FDA also conducts an extensive advertising campaign to deter retailers from selling tobacco products to minors. The NIH — through the National Cancer Institute, NIDA, and others — supports biomedical and clinical research on tobacco. SAMHSA, through its Substance Abuse Prevention and Treatment (SAPT) Block Grant, administers the Synar Amendment, which requires state legislative and enforcement efforts to reduce the sale of tobacco products to minors. Since the enactment of Synar in 1994, states increased retailer compliance rates from approximately 30 percent to 79 percent in 1998, reported in 1999.

States are at the forefront of efforts to prevent tobacco use by youth. Arizona, California, Florida, and Massachusetts are conducting paid anti-tobacco media campaigns restricting minors' access to tobacco, limiting smoking in public places, and supporting school-based prevention. CDC provides funding for state health departments and national organizations to conduct tobacco-use prevention and reduction programs, including media and educational campaigns, training, and surveys. The CDC's Office on Smoking and Health has developed a four-point prevention and control strategy to support state campaigns. CDC's Media Campaign Resource Center provides states with television and radio advertisements as well as printed materials. The federal government is responsible for the diffusion of science-based models and strategies in support of state and community efforts. Accordingly, the CDC funds evaluations of specific programs and disseminates information to the public. The CDC's *Guidelines for School Health Programs to Prevent Tobacco Use and Addiction*, for example, includes recommendations for tobacco-use policies, tobacco prevention education, teacher training, family involvement, tobacco-use cessation programs, and evaluation.

Youth Alcohol Use Prevention

SAMHSA and NIAAA have a variety of programs and projects to help curb underage alcohol use. Within SAMHSA's prevention and treatment budget, it is estimated that $88.6 million is designated to fight underage alcohol use and NIAAA targeted $36.3 million to curb youth alcohol abuse. HHS' existing projects include a collaboration between SAMHSA, NIAAA, and the Department of Education to fund five new grants, totaling approximately $2.9 million, to test a variety of interventions that have the potential to reduce alcohol abuse on college campuses, and a 5-year SAMHSA/NIAAA partnership, totaling $3.9 million annually, to fund research programs related to treatment among adolescents. NIAAA recently published "Make a Difference: Talk to Your Child About Alcohol," a guide for parents of kids, aged ten to fourteen years old. In addition, The National Youth Anti-Drug Media Campaign's pro-bono match requirement has generated more than twelve million dollars in public service advertising time and space for organizations like Mothers Against Drunk Driving and NCADD.

Comprehensive Prevention Systems

It has been well established that prevention works best when a comprehensive approach is used – including youth, family, school, and community activities. Results from SAMHSA/CSAP's Community partnership and coalition programs reflect the positive nature of such an approach.

SAMHSA/CSAP's State Incentive Grant (SIG) program is designed to coordinate all substance-abuse prevention funding within a state and to implement prevention programs in selected communities. This competitive grant program serves as an incentive for synchronizing state-wide prevention with private and community-based organizations. Eighty-five percent of SIG funds must be devoted to actual prevention programming, and 50 percent or more of the activities must involve science-based programs. To date, twenty-one grants have been awarded to states and the District of Columbia. Some governors report having leveraged as much as ten dollars for every one dollar invested. For example,

- In Vermont, funds from United Way agencies, Safe and Drug-Free Schools, and other grants from state and local agencies and private businesses have been merged to support local prevention activities.
- The SIG program in Oregon calls upon the state to work with every county to develop a comprehensive plan incorporating substance-abuse prevention in schools, the juvenile justice system, and teen pregnancy programs. The state is also working for the first time with nine tribal governments to implement substance-abuse prevention.
- In Kansas the SIG prompted the governor to issue an executive order establishing a Governor's Substance-Abuse Prevention Council. This Cabinet-level group has already conducted a county-level resource assessment and developed a science-based prevention publication that integrates guidelines and strategies across multiple federal and state funding sources.

To address the technical assistance and training needs of SIG states and community subrecipients, as well as non-SIG states, and facilitate the selection of science-based prevention models that meet community needs, SAMHSA/CSAP's Centers for the Application of Prevention Technologies (CAPTs) will be expanded.

TREATING ADDICTED INDIVIDUALS

Despite our best efforts, some people invariably will use drugs. A proportion will become addicted. Since this group causes untold damage to themselves, their families, and their communities, the addicted population must be targeted as a vital part of the *Strategy*. In a given year, addicts consume most of the heroin and cocaine in America. By reducing the number of addicts, we can greatly decrease the negative social and human consequences of drug abuse. Drugs have severe negative consequences for abusers' mental and physical health. Drug abuse also has tremendous implications for the health of the public since drug use is now a major vector for the transmission of infectious diseases, particularly HIV/AIDS, hepatitis, and tuberculosis. Because addiction is a complex and pervasive health issue, overall strategies must encompass a public-health approach, including extensive education and prevention, treatment, and research.

Research on Addiction[32]

Scientific research and clinical experience have increased our understanding of addiction, which is characterized by compulsive drug-seeking and use – even in the face of negative consequences. Virtually all drugs of abuse affect a single pathway deep within the brain: the mesolimbic reward system. Activation of this system appears to be what motivates substance abusers to keep taking drugs. Not only does acute drug use modify brain function in important ways, but prolonged drug use causes pervasive changes in the brain that persist long after the individual stops taking a drug. Significant effects of chronic use have been identified for many drugs at all levels: molecular, cellular, structural, and functional.

The addicted brain is distinctly different from the non-addicted brain, as manifested by changes in metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. Some of these long-lasting changes are unique to specific drugs whereas others are common to many substances. We can actually see these changes through use of imaging technologies, like positron emission tomography. Understanding that addiction is, at its core, a consequence of fundamental changes in brain function means that a major goal of treatment must be to compensate for brain changes through medication or behavior modification.

Addiction is not just a brain disease. The social context in which drug dependence expresses itself is critically important. The case of thousands of returning Vietnam veterans who were addicted to heroin illustrates this point. In contrast to addicts on the streets of America, many of the veterans were relatively easy to treat. American soldiers in Vietnam who became addicted did so in a totally different setting from the one to which they returned. At home in the United States, veterans were exposed to very few of the conditioned environmental cues that had been associated with drug use in Southeast Asia. Conditioned cues can be a major factor in causing recurrent drug cravings and relapse even after successful treatment.

Addiction is rarely an acute illness. For most people, it is a chronic illness with a significant volitional dimension. Total abstinence for the rest of one's life is relatively rare following a single experience in treatment. Relapses are not unusual. Thus, addiction must be approached like other chronic illnesses – such as diabetes and hypertension – rather than acute conditions, like a bacterial infection or broken bone. This approach has serious implications for how we evaluate treatment. Viewing addiction as a chronic illness means that a good treatment outcome may be a sizeable decrease in drug use and long periods of abstinence.

Status of Drug Treatment

A significant treatment gap – defined as the difference between individuals who would benefit from treatment and those receiving it – exists. According to recent estimates drawn from the National Household Survey on Drug Abuse (NHSDA), the Uniform Facility Data Set (UFDS), and other sources, approximately five million drug users needed immediate treatment in 1998 while 2.1 million received it. The NIAAA report, *Improving the Delivery of Alcohol Treatment and Prevention Services*, estimates that there are fourteen million alcohol abusers whereas the 1998 NHSDA found approximately ten million dependent on alcohol. Certain parts of the country have little treatment capacity of any sort. Likewise, some populations – adolescents, women with small children, and racial as well as ethnic minorities – are woefully under-served. According to the Child Welfare League of America, in 1997 only 10 percent of child welfare agencies were able to locate treatment within a month for clients who needed it.[33] According to SAMHSA, 37 percent of substance-abusing mothers of minors received treatment in 1997.[34] Some modalities – namely

methadone – fall short of needed capacity; 179,000 patients were in methadone treatment at the close of 1998. Furthermore, while treatment should be available to those who request it, society also has a strong interest in helping populations that need treatment but will not seek it. Drug-dependent criminal offenders and addicts engaging in high-risk behavior are important candidates for treatment, whether they want it or not.

Ultimately, calculations of the treatment gap should include both actual demand and populations that society has a special interest in treating due to the high social cost associated with their drug abuse. Starting in 2000, a new methodology – based on clinical criteria – will be employed in the NHSDA. This approach will provide improved national estimates by August 2001. More precise numbers will be helpful in determining the magnitude of the treatment gap and targeting resources to the areas where the gap is greatest.

Limited funding for substance abuse treatment is a major factor that restricts the availability of treatment. Over the last decade, spending on substance abuse prevention and treatment rose to an estimated annual level of $12.6 billion. Of this amount, public spending is estimated at $7.6 billion. The public sector includes Medicaid, Medicare, federal agencies like the Veterans Administration, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, and other state and local government expenditures. Private spending is estimated at $4.7 billion and includes individual out-of-pocket payment, insurance, and other non-public sources. One of the main reasons for the higher outlay in public spending is the frequently limited coverage by private insurers. The lack of coverage and recent changes in payment structures affect attitudes, resources, treatment plans, and the quality of treatment. Private and public insurers are not working collaboratively; thus, more public resources are utilized, and government funds – which were intended to be a safety net – have become a primary option for many individuals.

In addition to resource limitations, other factors limit treatment, including restrictive policies and regulations, incomplete knowledge of best practices, resistance to treatment on the part of certain populations in need, and limited information on treatment at the state and local level. Action in the following areas can make treatment more available:

1. Increase SAPT Block Grant funding to close the treatment gap.

2. Use funding under SAMHSA's Targeted Capacity Expansion program; expansion of services to vulnerable and underserved populations; more outreach programs for those at risk of HIV/AIDS; and increased community options for sanctions among criminal and juvenile justice clients.

3. Use regulatory change to make proven modalities more accessible: reform regulation of methadone/LAAM treatment, maintain and improve program quality; train treatment professionals and physicians to employ the proper administration of opiate agonists and emerging pharmacotherapies; conduct demonstrations of administration by doctors of opiate agonists; and provide comprehensive evaluation of the impact of regulatory reform on treatment access, quality, and cost.

4. Continue examining possible changes in policy to remove barriers, such as lack of parity in insurance coverage. For example, the President recently announced that the Federal Employees Health Benefits Plan (FEHB) would provide parity for both substance abuse and mental health services.

5. Review policies, practices, and federal statutory requirements, such as the statutory exclusion of Medicaid funding for Institutes for Mental Disease (IMD), which may affect access to residential treatment services for substance abuse.

6. Prioritize research, evaluation, and dissemination – including state-by-state estimates of drug-treatment need, demand, and treatment resources; dissemination of best treatment practices; guidance on ways to increase retention and reduce relapse; and foster progress from external coercion to internal motivation.

7. Reduce stigma associated with drug treatment.

To improve treatment accountability, ONDCP is piloting an information system with treatment programs around the country that will be expanded by DHHS into the National Treatment Outcome Monitoring System (NTOMS). Under NTOMS, treatment performance will be measured and compared. In addition, an agreement has been negotiated with the states to establish a common set of outcome measures to be applied to programs receiving federal funding.

Treatment services are being fostered through manuals created by NIDA, Treatment Improvement Protocols and addiction curricula by CSAT, clinical guidelines by the Department of Veterans Affairs (VA), and a comprehensive curriculum for treatment by the Federal Bureau of Prisons (BOP). State and local treatment programs with promising results are applying these resources. CSAT has joined with the Certification Board for Addiction Profes-

sionals of Florida and a number of national stakeholder organizations to develop core competencies for substance-abuse counselors. Ultimately, these efforts will lead to a body of certified professionals equipped with manuals reflecting the most advanced approaches to treatment.

Adolescents with alcohol and drug problems are not adequately served in most existing drug treatment programs designed for adults. Adolescents rarely seek help for problems related to drug and alcohol use. Referrals by juvenile courts are too often the first intervention. By this time, substance abuse has contributed to delinquent behavior, violence, and high-risk activities. There is also a paucity of research-based information about juvenile treatment. SAMHSA/CSAT, in collaboration with NIAAA, is supporting a five-year research grant, titled *Treatment for Adolescent Alcohol Abuse and Alcoholism*, which will contribute to the development of good programs for adolescents.

Services for Women

Although women use illegal drugs at lower rates than men, they experience the abuse and consequences of drugs and alcohol differently and require gender-appropriate prevention and treatment. Women who use illegal drugs, alcohol, or tobacco during pregnancy create health risks for themselves and their unborn children. Exposure to alcohol in utero is associated with Fetal Alcohol Syndrome, Fetal Alcohol Effects, infant mortality and morbidity, attention deficit disorder, and other health problems. Women face unique barriers to treatment, such as the stigma associated with being a substance-abusing mother, fear of losing housing or custody of children, and lack of child care. Substance abuse by older women, including alcohol and misuse of prescription and over-the-counter drugs, is a problem that merits more attention as our population ages.

Women in recovery from drug abuse are likely to have a history of violence and trauma. Consequently, they may be suffering from post-traumatic stress disorder. SAMHSA is addressing this issue in a two-phased study on Women, Co-Occurring Disorders, and Violence. This study seeks to discover ways to improve outcomes following substance abuse. In addition, the study promotes improved coordination of services through an integrated delivery system.

Substance Abuse and Co-occurring Mental Disorders

According to the National Comorbidity Survey, more than 40 percent of persons with addictive disorders also have co-occurring mental disorders. Data suggests that mental disorders precede substance abuse more than 80 percent of the time, generally by five to ten years.[35] We must take advantage of this window of opportunity to predict drug abuse and prevent it. In addition, treatment providers must recognize co-occurring mental disorders and addiction in order to prevent relapse and improve the likelihood of recovery.

Roughly ten million people in the United States have co-occurring substance abuse and mental disorders. These individuals experience more severe symptoms and greater functional impairment than persons with a single disorder, have multiple health and social problems, and require more care. In addition, dual disorders are often associated with unemployment, homelessness, contact with law enforcement, and other medical problems like HIV/AIDS.

According to the Department of Veterans Affairs, about a third of adult homeless people once served their country in the armed services. On any given day, as many as 250,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year. About 45 percent of homeless veterans suffer from mental illness, and 70 percent have alcohol or other drug abuse problems. Considerable overlap exists between these two categories.

Treatment of co-occurring substance abuse and mental health disorders have historically been provided by multiple service delivery systems, which at times have been at odds with one another organizationally, philosophically, and financially — often to the detriment of the people in need. A new paradigm is necessary to provide services for a spectrum of co-occurring disorders. Early intervention, integrated treatment, cross training of staff, licensing of medical personnel (psychiatrists, psychologists, etc.), consistent qualifications for other mental-health and addiction personnel, and sufficient funding are among the areas where innovative solutions are badly needed. Long-term studies of co-occurring disorders can help identify the best courses of treatment.

Parity for Substance-Abuse Treatment

From a scientific standpoint, management of addiction is similar to treating other chronic illnesses. Were insurance parity in place, substance abuse treatment would be subject to the same benefits and limitations as other comparable disorders. Unfortunately, most employer provided insurance policies currently place greater burdens on patients in terms of cost-sharing, co-payment, and deductibles while offering less coverage for the number of visits or days of coverage and annual dollar expenditures for treatment. Many health insurance companies impose lower lifetime limits on amounts that can be expended for drug and alcohol treatment than for other illnesses. Parity for substance abuse treatment would correct these unfair practices and expand the amount of available treatment.

Parity is affordable. According to the SAMHSA report *The Costs and Effects of Parity for Mental Health and Substance Abuse Insurance Benefits*, the average premium increase due to full parity would be 0.2 percent — just a dollar per month for most families. Furthermore, other medical expenses incurred by treated patients are less than for untreated clients. Therefore, substance abuse prevention and intervention saves employers money in both the short and long term. Documentation and validation of best practices for health service providers are currently being prepared. These figures will include added cost offset, cost benefit, and cost utility incentives for both private- and public-sector employers.

Ending the disparity between drug abuse and other diseases through legislation would reduce the treatment gap. Such action could be particularly useful for adolescents who are covered by parents' insurance plans. Parity legislation will help lessen demands by people with private insurance on publicly funded treatment. Parity and the ensuing privatization of treatment would encourage more effective interventions. Indeed, the lack of private insurance for drug-abuse treatment discourages the development of new therapies.[86] Legislation supporting parity will move drug treatment further into the mainstream of health care and reduce the stigma associated with addiction.

The federal government has taken an historic step with regard to drug abuse and is serving as a model for other employers. In June 1999, the President announced that the Federal Employee Health Benefit Program (FEHB) would offer parity for mental health and substance abuse coverage by 2001. This unprecedented initiative will provide access to treatment for nine million people including federal employees, retirees, and their families. This move underscores the federal government's commitment to quality coverage for mental illness, substance abuse, and physical illness. In December, the FEHB began working with small businesses to provide these benefits.

Medications for Drug Addiction

Pharmacotherapies are essential for reducing the number of addicted Americans. Methadone therapy, for example, is one of the longest-established, most thoroughly evaluated forms of drug treatment. NIDA's Drug Abuse Treatment Outcome study found that methadone treatment reduced participants' heroin use by 70 percent and criminal activity by 57 percent while increasing full-time employment by 24 percent. A 1998 review by the General Accounting Office put the situation this way: "Research provides strong evidence to support methadone maintenance as the most effective treatment for heroin addiction." Methadone therapy helps keep more than 179,000 addicts off heroin, off welfare, and on the tax rolls as law-abiding, productive citizens. "A Notice of Proposed Rule Making" — published in the *Federal Register* on July 22, 1999 — proposed a new system of federal oversight for opioid treatment programs. This approach would transfer regulatory oversight from FDA to SAMHSA, provide greater flexibility to practitioners, and require program accreditation as a means of implementing best practice guidelines.

Buprenorphine is another medication under consideration for the treatment of opiate addiction. Buprenorphine and the combination drug Buprenorphine/Naloxone were developed under a cooperative research and development agreement between NIDA and a private corporation. Buprenorphine shares some, but not all, of the properties of an opiate. Unlike methadone, which is a full agonist, Buprenorphine is a "partial" agonist. In other words, it possesses both agonist and antagonist properties and therefore may pose less potential for abuse or overdose.* Another benefit of Buprenorphine is that the withdrawal syndrome that occurs upon discontinuation is mild to moderate and often can be managed without the administration of other medications.

* An agonist is a drug that activates a receptor in a manner that mimics the action of the natural neurotransmitter; an antagonist is a drug that occupies the receptor of a natural neurotransmitter but does not activate it, thus producing a functional blockade of the postsynaptic neuron.

NIDA will continue funding a high priority program to discover new medications for treating drug abuse. These research projects could result in new pharmacotherapies. Specific projects include development of an anti-cocaine agent, a controlled-release dosage of oral methadone, medications to treat withdrawal symptoms in babies born to opiate-dependent mothers, and medicines for methamphetamine addiction. Under ONDCP/CTAC sponsorship, Columbia University College of Physicians and Surgeons has been synthesizing highly active protein compounds of catalytic antibodies, which will act as a peripheral blocker and reduce serum cocaine concentrations in the blood. SAMHSA will develop treatment standards for new medications, as required by the Narcotic Addict Treatment Act (NATA).

Behavioral Treatment Initiative

Behavioral therapies remain the only effective treatment for many drug problems, including cocaine addiction, where viable medications do not yet exist. Furthermore, behavioral intervention is needed even when pharmacological treatment is being used. An explosion of knowledge in the behavioral sciences is ready to be translated into new therapies. NIDA is encouraging research in this area to determine why particular interventions are effective, develop interventions that could reduce AIDS risk behavior, and disseminate new interventions to practitioners in the field. More specifically, this initiative will focus on adolescent drug use.

National Drug Abuse Treatment Clinical Trials Network

Over the past decade, NIDA-supported scientists have improved pharmacological and behavioral treatment for drug addiction. However, most of the newer methods are not widely used in practice because they have been studied in relatively short-term, small-scale contexts conducted in academic settings on stringently selected populations. To reverse this trend and improve treatment nationally, NIDA is establishing a National Drug Abuse Treatment Clinical Trials Network (CTN) to conduct large, rigorous, statistically powerful, multi-site studies in community settings using diverse patients. Science-based therapies that are ready for testing in the CTN include new cognitive behavioral therapies, operant therapies, family therapies, brief motivational enhancement therapy, and manualized approaches to individual and group drug counseling. Among the medications to be studied are: naltrexone, LAAM, buprenorphine for heroin addiction, and a few other substances currently being developed by NIDA for use against cocaine addiction.

Practice Research Collaboratives Program (PRC)

This SAMHSA/CSAT-supported initiative will improve the quality of substance-abuse services by increasing interaction and knowledge exchange among community-based stakeholders, including drug-abuse treatment providers, researchers, and policy makers. Nine grantees have been funded to create the necessary infrastructure for bridging the gap between research and practice in various parts of the country. During an implementation phase, PRCs will develop a provider-based knowledge agenda, create a provider-based research infrastructure, and implement studies on the application of evidenced-based practices in community settings.

Treatment Research and Evaluation

NIDA supports over 85 percent of the world's research on drugs of abuse. Recent studies of pharmacotherapies and behavioral therapies for abuse of cocaine/crack, marijuana, opiates, and stimulants (including methamphetamine) will improve the likelihood of successfully treating substance abuse. In addition, a comprehensive epidemiological system needs to be developed to measure the success of new therapies. NIDA will conduct clinical and epidemiological research to improve the understanding of drug abuse among children and adolescents. These findings will be widely disseminated to assist in finding more effective approaches to prevention. ONDCP/CTAC is sponsoring the development of the Drug Evaluation Network System (DENS), which will monitor and evaluate substance-abuse programs by tracking patients entering treatment, their characteristics, and discharge status. This information will be online and made available to treatment providers, researchers, and managers. To ensure that basic research is put to good use, SAMHSA supports applied research. For example, SAMHSA/CSAT's Methamphetamine Treatment Project (http://www.methamphetamine.org) is funding evaluations of sixteen-week methamphetamine interventions in non-residential (outpatient) psychosocial settings in California, Hawaii, and Montana. The objective is to determine whether promising results from stimulant treatment attained by the MATRIX Center in Los Angeles can be replicated.

Research into the Mechanisms of Addiction

Advanced brain imaging technology is being made available — under ONDCP/CTAC funding to research scientists working on grants from NIDA — to identify the underlying causes of substance abuse. Over the last two years, CTAC has sponsored the development of advanced brain imaging at several leading research facilities throughout the country:

- Functional Magnetic Resonance Imaging to map brain reward circuitry, blood volume and flow associated with drug metabolism, and interactions with potential therapeutic medicines (Massachusetts General Hospital and Emory University)

- Positron Emission Tomography (PET) for ultra high resolution of neurobiological substrates of addiction via use of radioisotope tracers (University of Pennsylvania)

- Magnetic Resonance Spectroscopy to image the drug's metabolic and chemical processes (Harvard University/ McLean Hospital)

Reducing Infectious Disease among Injecting Drug Users

Although the number of new AIDS cases has declined dramatically during the past two years because of the introduction of combination therapies, HIV infection rates have remained relatively constant. CDC estimates that 650,000 to 900,000 Americans are now living with HIV, and at least forty-thousand new infections occur each year. HIV rates among African Americans and Hispanics are much higher than among whites. Studies of HIV prevalence among patients in drug-treatment centers and women of child-bearing age demonstrate that the heterosexual spread of HIV in women closely parallels HIV among injection drug users (IDUs). The highest prevalence rate in both groups has been observed along the East Coast and in the South. Hepatitis B and C are also spreading among IDUs. IDUs represent a major public-health challenge. Addicted IDUs frequently have multiple health, psychological, and social problems that must be overcome in order to address their addiction, criminal recidivism, and disease transmission.

NIDA has created a center on AIDS and Other Medical Consequences of Drug Abuse to coordinate a comprehensive, multi-disciplinary research program that will improve the knowledge base about drug abuse and its relationship to other illnesses through biomedical and behavioral research. This work will incorporate a range of scientific investigation from basic molecular and behavioral research to epidemiology, prevention, and treatment. Information from each of these areas is essential for understanding the links between drug abuse and AIDS, TB, and hepatitis and for developing strategies for stemming infectious diseases spread through injection drug users. NIDA is conducting public-health campaigns to increase awareness of infectious diseases.

SAMHSA will continue its support of early intervention services for HIV through the SAPT block grants. Under the Congressional Black Caucus Initiative aimed at reducing the disproportionate impact of HIV/AIDS on racial and ethnic minorities, SAMHSA awarded 108 new grant totaling over $39 million. In FY 2000, SAMHSA expects to award in excess of $60 million to fund outreach, substance abuse prevention and treatment, and prevention services for women and youth in communities of color. The grants from SAMHSA's Targeted Capacity Expansion and Outreach Programs will improve substance-abuse treatment and prevention services in minority communities highly affected by the twin epidemics of substance abuse and HIV/AIDS.

Training for Substance-Abuse Professionals

Many health-care professionals lack the training to identify the symptoms of substance abuse. Most medical students, for example, receive little education in this area. If physicians and other primary-care managers were more attuned to drug-related problems, abuse could be identified and treated earlier. Many competent community-based treatment personnel lack professional certification. Consequently, SAMHSA/CSAT has worked collaboratively with the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and the International Certification Reciprocity Consortium/Alcohol and Other Drugs (ICRC) to improve the states' credentialing systems that respect the experiences of individual treatment providers while they earn professional credentials. CSAT's publication *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* — compiled in consultation with CSAT's National Curriculum Committee of the Addiction Technology Transfer Centers, NAADAC, ICRC, International Coalition of Addiction Studies Educators (INCASE), and the American Academy of Health Care Providers for the Addictive Disorders — offers a framework for the acquisition of knowledge and skills required for counselor certification.[37]

Providing Services for Vulnerable Populations

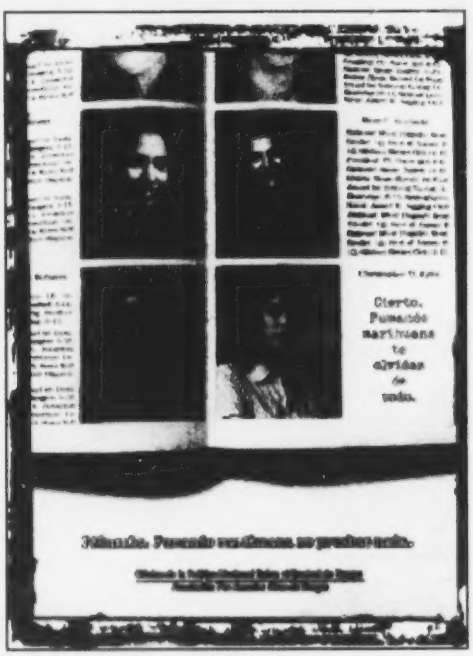
For prevention and treatment to be effective, we must address the unique needs of different populations. As a result of managed care and changes in the welfare and health-care system, much-needed services may be less available to vulnerable populations, including racial and ethnic minorities like African-Americans, Native Americans, Alaskans, Hispanics, Asian American/Pacific Islanders; children of substance-abusing parents; the disabled; the poor; the homeless; and people with co-occurring substance abuse and mental disorders. SAMHSA/CSAT is addressing this problem in the Targeted Capacity Expansion Program, which responds to the treatment needs of serves these vulnerable populations. Our overall challenge is to help chronic drug abusers overcome dependency and lead healthy, productive lives. In addition, SAMHSA/Center for Mental Health Service's PATH program supports services to individuals who are homeless or at risk of homelessness, including homeless families. Three out of every five clients served through this program also have a co-occurring substance abuse disorder.

TRANSLATION

It's true.
If you smoke marijuana
you forget everything.

Think about it. If you smoke marijuana
you prove nothing.

Office of National Drug Control Policy
Partnership for a Drug-Free America



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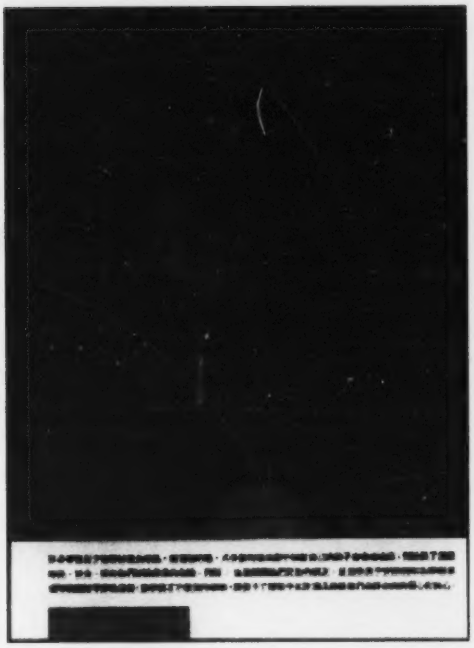

TRANSLATION

For Too Many Parents,
Drugs Can Cause Blindness

Many [Chinese, Filipino, Korean, Vietnamese, Japanese] children have tried drugs. Sadly, too many parents don't believe that their own children could use drugs. There are several things you can do to help keep your children's life drug-free. First of all, talk with them about the dangers of drugs. Also, know who their friends are,
and make sure that your children have something to do after school like homework or sports. Let them see that you care about keeping drugs out of their future.

Office of National Drug Control Policy
Partnership for a Drug-Free America

TRANSLATION

Don't Let Drugs Change Your Child's Future

You can do a lot of things to make sure your child's life is drug free. First of all you can talk: teens who say they've learned about the dangers of drugs from their parents are 43% less likely to try marijuana. To be more effective, know who your child's friends are and what your child does when you're not around. If you don't do anything about drugs, drug user and dealers will. And they could care less about your child's future.

Office of National Drug Control Policy
Partnership for a Drug-Free America

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BREAKING THE CYCLE OF DRUGS AND CRIME

Drug-dependent individuals are responsible for a disproportionate percentage of our nation's violent and income-generating crimes like robbery, burglary, or theft. According to ADAM data, between one-half and three-quarters of all arrestees tested in the thirty-five cities around the country had drugs in their system at the time of arrest. About half of those charged with violent or income-generating crimes test positive for more than one drug. In 1997, a third of state prisoners and about one in five federal inmates said they had committed the offenses that led to incarceration while under the influence of drugs. Nineteen percent of state inmates and 16 percent of federal inmates said they committed their current offense to obtain money for drugs (up from 17 percent and 10 percent, respectively, in 1991).[38]

The nation's incarcerated population is now more than 1.8 million. According to 1998 data (the latest data available), almost 60 percent of inmates in federal prison are sentenced for drug offenses, up from 52.3 percent in 1990.[39] Time served for these offenses more than doubled between 1986 and 1997, rising from 20.4 months to 42.5 months. In the same period, overall time served nearly doubled, mostly due to increased penalties for drug, weapon, and immigration offenses. Increases for violent crime (9 percent) and property crime (1 percent) were modest by comparison. State prisons are also experiencing significant growth in the population of drug offenders: 21 percent of state prisoners in 1997 were incarcerated for drug law violations. Between 1990 and 1997, the number of drug offenders in state prison grew by 77,000.

Given the link between drugs and crime, reducing the number of drug-dependent criminals would decrease the amount of drugs consumed, the size of illegal drug markets, the number of dealers, and the incidence of drug related crime and violence. The corrections and treatment professions must join in common purpose to break the tragic cycle of drugs and crime by reducing drug consumption and recidivism among individuals in the criminal justice system. We should accelerate the expansion of programs that offer alternatives to imprisonment for non-violent drug offenders. Treatment must be made more available for drug-dependent inmates and those on probation or parole. Finally, adequate transitional programs should support inmates following release. The end result will be fewer addicts and drug users, less demand for drugs, reduced drug trafficking, decreased drug-related crime and violence, safer and healthier communities, and fewer people behind bars. The criminal justice system has already made much progress in providing treatment for offenders in correctional settings and the community, but these programs can be expanded Many juvenile and adult offenders who abuse or are dependent on drugs and alcohol also have co-occurring mental disorders and primary health care needs. For example, approximately thirteen percent of the prison population has both a serious mental illness and a co-occurring substance abuse disorder, and many others have or are at risk for HIV/AIDS and other infectious diseases. To be maximally effective, treatment must address these co-occurring health conditions, must be appropriate to the age and gender of the offender, and must be appropriate to the offender's race and ethnic heritage. When appropriate, treatment should also involve the offender's family. The children of substance abusing offenders are at higher risk for substance abuse and criminal behavior themselves. Therefore, treatment which involves the offender's family can help to break the intergenerational cycle of substance abuse and crime.

Substance Abuse Treatment for Incarcerated Offenders

Both state and federal agencies have established substance-abuse treatment programs in correctional institutions. Incarcerating offenders without treating underlying substance abuse simply defers the time when addicts return to the streets and start harming themselves and the larger society. As a crime-control measure alone, drug treatment for criminally active addicts is strikingly cost-effective. It offers the potential of reducing crime by two-thirds at about half the cost of incarceration alone.

According to the Federal Bureau of Prisons (BOP), the number of federal inmates receiving residential substance-abuse treatment increased from 1,236 in 1991 to 10,816 in 1999.[40] BOP provides drug treatment for inmates prior to release. The number of federal institutions offering residential treatment has grown from thirty-two to forty-four since 1994. In 1998 nearly 34,000 inmates participated in all types of BOP treatment services. A joint BOP/NIDA study of these programs resulted in an interim report addressing the first six months after release from custody. This period is significant because recidivism is generally highest within the first year after prison. The study found that the treated population was 73 percent less likely to be re-arrested and 44 percent less likely to use drugs than a comparison group that received no treatment.[41]

The Corrections Program Office of the U.S. Department of Justice funded 118 state projects for substance-abuse treatment through Residential Substance Abuse Treatment (RSAT) for State Prisoners grants. One example of these projects is Delaware's in-prison program, which has offered institutional and transitional drug treatment since the late 1980s. The population that participated in both institutional and transitional treatment programs was 69 percent arrest-free and 35 percent drug-free three years after release from custody, compared to 29 percent and 5 percent, respectively, for the non-treated group.[42]

The Drug-Free Prison Zone Demonstration Project

This initiative is being conducted jointly by ONDCP, the National Institute of Corrections, and BOP to reduce the availability of drugs in prisons. The program combines policy, testing, technology, treatment, and training – including a program of regular inmate drug testing, the use of advanced technologies (e.g., ion spectrometry) for detection of drugs entering facilities, and the training of correctional officers and other institutional staff.

Detection technology contributed to a recent evaluation of Pennsylvania's comprehensive drug interdiction program. The results showed that drug use went down 64 percent, drug finds decreased by 41 percent, assaults on staff were reduced by 57 percent, assaults on other inmates dropped 70 percent, and the number of weapons seized declined by 65 percent. Similarly, at the Federal Correctional Institution in Tucson and the Metropolitan Detention Center in Los Angeles, detection technology produced a reduction in the rate of serious drug-related inmate misconduct (introduction, use, or possession of drugs) by 86 percent and 58 percent, respectively.

Twenty eight BOP facilities are gathering information on visitor screening, inmate drug-testing, and five types of inmate misconduct. Eight states (Alabama, Arizona, California, Florida, Kansas, Maryland, New Jersey, and New York) began participating in January 1999 and are employing a variety of education, training, interdiction, and treatment measures. The initiative is being independently evaluated, and interim findings from BOP are expected by mid-2000 and from the states by the end of 2000.

Operating Standards for Prison-Based Therapeutic Communities (TCs)

The field-testing of operating standards was conducted by Therapeutic Communities of America (TCA) with ONDCP support. The resulting document was made available in December 1999. This groundbreaking contribution brings a new level of discipline to practitioner discussions of drug treatment. A comprehensive set of operating standards for prison-based TCs – over 120 across eleven program domains – has now been validated in operational prison settings. In its present form, the standards provide a blueprint for state and local leaders, and they will eventually be put into a format appropriate for use by national accrediting organizations. In the interim, continuing leadership by TCA and other professional groups will be needed to provide guidance for the application of emerging standards and manuals.

Substance-Abuse Treatment Provided with Community Supervision

In 1996, states and localities spent over $27 billion in corrections, of which $21 billion was used for prison operations alone. The average annual cost per inmate was $20,142, ranging from a low of $8,000 to a high of $37,800. For the federal system, the annual cost per inmate was $23,500. By comparison, probation and parole costs in 1997 ranged from $1,110 per year for regular supervision to $3,470 for intensive supervision, and $3,630 for electronic supervision. Cost variation is explained primarily by caseload. The average caseload for regular probation was 175, and sixty-nine for regular parole. Average caseloads for intensive supervision probation and parole were thirty-four and twenty-nine, respectively; electronic supervision was twenty and eighteen.

Using the Federal Bureau of Prisons as a representative program, the annual cost of residential and transitional treatment and services was estimated at $3,000 per inmate. Generally accepted estimates of annual treatment costs per person in the community are: regular outpatient, $1,800; intensive outpatient, $2,500; short-term residential, $4,400; and long-term residential, $6,800. Combining the most expensive community supervision with the most expensive treatment yields an estimated average cost of $10,430 per person per year compared to $20,142 for incarceration alone, and $23,142 for incarceration combined with treatment and transitional services. Drug courts, TASC, BTC, and Zero Tolerance have all helped make community supervision and treatment more effective.

Criminal Justice Treatment Networks

CSAT's Criminal/Juvenile Justice Treatment Networks (CJTN) project, a five-year systems integration initiative launched in FY95, continued its fifth year of federal funding in FY99. The networks have developed an integrated system of intake, supervision, and treatment across justice agencies for adult and juvenile offenders in eight metropolitan jurisdictions. In this past year, the networks expanded services and partnerships. In FY 1999, SAMHSA/CSAT published *Strategies for Integrating Substance Abuse Treatment and Juvenile Justice Systems: A Practice Guide*, which describes the range of substance-abuse treatment services provided in juvenile justice settings.

Drug Courts

Drug courts divert drug offenders out of jails or prisons and refer them to community treatment. Drug courts seek to reduce drug use and associated criminal behavior by retaining drug-involved offenders in treatment. Defendants who complete the program either have their charges dismissed (in a diversion or pre-sentence model) or probation sentences reduced (in a post sentence model). Title V of the Violent Crime Control and Law Enforcement Act of 1994 (P.L. 103-322) authorizes the Attorney General to make grants to state and local governments to establish drug courts. In October 1999, 416 drug courts were operating nationwide, including eighty-one juvenile, eleven tribal, ten family, and seven combined drug courts. Two hundred and seventy-nine were in planning stages, up from a dozen in 1994.[43]

Drug courts have been an important step forward in diverting non-violent offenders with drug problems into treatment and other community resources, leaving the criminal justice system to address violent acts. One hundred and seventy-five thousand people have entered drug courts since their inception, and 122,000 graduated or remained active participants. A review of thirty evaluations involving twenty-four drug courts found that these facilities keep felony offenders in treatment or other structured services at roughly double the retention rate of community drug programs. Drug courts provide closer supervision than other treatment programs and substantially reduce drug use and criminal behavior among participants.[44]

CSAT, in collaboration with OJP's Drug Court Program Office, the National College of Juvenile and Family Court Judges, and the National Association of Drug Court Professionals is piloting three Family Drug Courts projects in which alcohol and other drug treatment, combined with intervention and support services for children and families, are integrated into the legal processing of the family's case. In some jurisdictions there is coordination between the criminal courts and the civil Family Drug Court. Family Drug Courts should be able to help states comply with the Adoption and Safe Families Adoption Act of 1997, P.L. 105-89. Family Drug Courts will substantially reduce the time taken for final disposition of abuse and neglect cases and will increase the percentage of family reunifications.

Treatment Accountability for Safer Communities (TASC)

Created in the early 1970s and originally named Treatment Alternatives to Street Crime, TASC has demonstrated that the coercive power of the criminal justice system can be used to get individuals into treatment and manage their behavior without undue risk to communities. Through TASC, some drug offenders are diverted out of the criminal justice system into community-based supervision. Others receive treatment as part of probation, and still others are placed in transitional services as they leave an institutional program. TASC monitors client progress and compliance — including expectations for abstinence, employment, and improved personal and social functioning — and reports results to the referring criminal-justice agency.[45]

Breaking the Cycle (BTC)

BTC encompasses the integrated application of testing, assessment, referral, supervision, treatment and rehabilitation, routine progress reports to maintain judicial oversight, graduated sanctions for noncompliance, relapse-prevention and skill-building, and structured transition back into the mainstream community. Since its inception in Birmingham, Alabama in June 1997, 8,385 assessments have been conducted with felony offenders to ascertain treatment needs; 2,395 offenders are currently active within the BTC Program. Over 72,000 drug tests were performed on offenders. Some 6,600 treatment referrals were made at the point of assessment. A bond was implemented requiring felony offenders to report to TASC within forty-eight hours for assessment and urinalysis. The period of time that elapsed between a BTC offender's entry into the system and his/her TASC assessment dropped from twenty-four days in December 1997 to four days in August 1999. Disposition alternatives, including deferred

and expedited dockets, have been established. These sentencing options were designed to utilize BTC compliance information to qualify defendants for early dispositions. By diverting these cases prior to the grand jury, circuit court docket space is available for jail cases. This "rocket docket" allowed Birmingham to postpone construction of a new jail pending full review of needs.

According to results of the 1998 Arrestee Drug Abuse Monitoring Program, 67.1 percent of male offenders tested positive for drug use at the time of arrest. By contrast, only 23 percent of BTC offenders tested positive during routine random urinalysis after intervention occurred. Retention rates exceeded 70 percent, and the re-arrest rate remained in the single digits. A Policy and Advisory Oversight Committee composed of criminal justice representatives proactively identified systemic barriers and made substantial steps to develop solutions, including the development of a management information system to automate the assessment, offender tracking, and drug testing conducted by TASC.

Birmingham's success led to the expansion of the demonstration to three additional sites for adult offenders in Jacksonville, Florida and Tacoma, Washington and for juvenile offenders in Eugene, Oregon. These sites are now beginning implementation.

Zero Tolerance Drug Supervision Initiative

This Presidential initiative proposes comprehensive drug supervision to reduce drug use and recidivism among offenders. The federal government will help states and localities implement tough new systems to drug-test, treat, and sanction prisoners, parolees, and probationers. This initiative will ensure that states fully implement the comprehensive plans to drug-test prisoners and parolees as required by law. Results must be submitted to the Justice Department. This initiative also supports efforts by states like Maryland and Connecticut to begin drug-testing probationers on a regular basis.

Initiatives Currently Underway

Over the past two years, ONDCP has joined with DOJ and HHS to lay the foundation for systemic collaboration between justice and public health. Working together, these federal agencies have documented the state-of-the-science at the March 1998 consensus meeting of scholars, clinicians, and other practitioners and then proceeded on two fronts:

- Applying the science: expanding breaking-the-cycle demonstrations to additional sites, demonstrating interdiction, intervention policies, and technology through the drug-free prison zone demonstration, and validating operating standards for prison-based TCs.
- Crafting a policy – in concert with federal, state, and local agencies as well as national organizations – to contribute to public safety and health.

This science-based policy calls for the criminal and juvenile justice systems to operate together with other service systems as a series of intervention opportunities for disordered drug and alcohol offenders. Intervention must be systematically applied as early as possible:

- To prevent entry into the criminal/juvenile justice system of individuals who can be safely diverted to community social-service systems;
- To limit entry into the criminal/juvenile justice system of adult and juvenile nonviolent offenders through community justice interventions in concert with other social-service systems; and
- To intervene with people who must be incarcerated or securely confined, through appropriate treatment and supervision, both during and after the period of confinement.

One example of a current initiative is the Department of Justice's Operation Drug TEST (Testing, Effective Sanctions, and Treatment). This program is a pilot project designed to identify drug abusing defendants as soon as they enter the federal criminal justice system and to provide appropriate supervision, sanctions, and treatment to help them become and remain drug-free. It was developed in response to a 1995 Presidential directive to the Attorney General, who worked to secure the strong support of the federal judiciary for this project. The Department of Justice and the Administrative Office of the United States Courts (AO) entered into a Memorandum of Understanding and began implementing the program in 25 federal judicial districts in fiscal year 1997. One of these districts opted out of the program, leaving 24 as the core initial group. Since 1997, $4.7 million annually has been allocated for this program.

Future Focus and Initiatives

In December 1999, a National Assembly of over eight-hundred state and local officials, national organizations, and federal leaders gathered in Washington, D.C. to address drugs, alcohol abuse, and the criminal offender. The assembly represented an unprecedented collection of health and justice professionals from all branches and levels of government. It focused on what needs to happen for different service systems to enhance public safety and health. The assembly worked toward consensus on policy to guide action. Finally, it established clear expectations within government: operating as teams, developing action plans to implement sound policy, providing access to best practices, and offering one-stop technical assistance and training. Work is underway to establish a schedule for follow-through with each state.

In developing future strategies for expanding substance-abuse treatment within the criminal justice system, participants in the National Assembly expressed concern over: 1) the needs of juveniles; 2) the importance of keeping treatment providers in contact with all other agencies — i.e. welfare, healthcare, and legal — involved in monitoring the offender; and 3) the way in which treatment effectively deals with dually-diagnosed offenders.

System Integration

Another challenge for the justice system is to reach beyond the immediate defendant and address family crises, domestic violence, juvenile delinquency, abuse and neglect, and a host of related problems. The justice system must incorporate means of intervening in a child's first problems with adults — often in his or her own home during the early years of life. Community involvement in legal issues, particularly when they intersect with families and children, is essential for breaking the cycle of substance abuse, crime, and violence. An example of this concept in action is New Jersey's Unified Family Courts, which encompass a network of six thousand volunteers who bring together diverse segments of the court and community to collaborate on effective approaches to families in crisis.

ENFORCING THE NATION'S LAW

The correlation between drugs and crime is high. Drug users commit crimes at several times the rate of people who do not use drugs. More than 51 percent of inmates reported substance abuse while committing the offense that led to their conviction.[46] The heavy toll drug abuse exacts on the United States is reflected in related criminal and medical costs totaling over $67 billion. Almost 70 percent of this figure is attributable to the cost of crime.[47]

Law enforcement professionals show supreme dedication and face risks daily to defend citizens against criminal activity. Since 1988, nearly seven hundred officers throughout the country have been killed in the line of duty, and over 600,000 were assaulted. We owe a debt of gratitude to the men and women who put their lives on the line in defense of our safety.

The United States is based on the rule of law that ensures the security of all people. Reducing drugs and crime is one of the nation's most pressing social problems. Trafficking and use of illicit drugs are inextricably linked to crime and place a tremendous social and economic burden on our communities. Drugs divert precious resources that support the quality of life all Americans strive to achieve. Illegal drugs create widespread problems that produce fear, violence, and corruption. Residents are afraid to go out of their homes, legitimate businesses flee urban neighborhoods, and the quality of life suffers. The data in Chapter II documents the nexus between drugs and crime. Strong law-enforcement policies contribute a great deal to reducing drug abuse and its consequences by:

Reducing demand — Through enforcing the laws against drug use, police strengthen social disapproval of drugs and discourage substance abuse. Moreover, arrest — and the resulting threat of imprisonment — offer a powerful incentive for many addicts to take treatment seriously.

Disrupting supply — The movement of drugs from sources of supply to our nation's streets requires sophisticated organizations. When law enforcement detects and dismantles a drug ring, less heroin, cocaine, methamphetamine, or marijuana finds its way to our streets. Seizures reduce availability.

To use the power of law enforcement effectively, the *Strategy* promotes coordination, intelligence sharing, advanced technology, equitable sentencing policies, and a focus on criminal targets that cause the most damage to our nation.

Law Enforcement Coordination

In unity there is strength. The more local, state, federal, and tribal law-enforcement operations reinforce one another; the more they share information and resources; the more they "deconflict" operations, establish priorities, and focus energies across the spectrum of criminal activities – the more successful will be the outcome of separate activities. The illegal drug trade is not a local but a national problem that is, in fact, international in scope. Drug trafficking gangs do not confine their activities to limited geographic boundaries. Accordingly, various federal, state, and local agencies have joined forces on national and regional levels to achieve better results. The El Paso Intelligence Center and the National Drug Intelligence Center (in Johnstown, Pennsylvania) produce strategic assessments of the drug threat and direct support to state and local law enforcement.

An example of outstanding collaborative efforts among law-enforcement agencies was the partnership between the United States Marshals Service (USMS), United States Customs Service, and Internal Revenue Service in 1999. That year, the USMS arrested more than twenty-five thousand federal and fourteen thousand state and local fugitives. Over 85 percent of such arrests have a drug component. USMS leads fifty-four federal, state, and local Fugitive Apprehension Teams.

The Departments of Justice and Treasury have developed the Special Operations Division (SOD) – a multi-agency national law-enforcement entity composed of agents, analysts, and prosecutors from the DEA, FBI, Customs, and the Narcotic and Dangerous Drug Section of Justice's Criminal Division. SOD coordinates regional and national investigations against major drug-trafficking organizations threatening the United States – particularly transnational organizations. SOD works closely with OCDETF, HIDTA, and U.S. Attorneys' offices across the country. These operations also frequently depend on the cooperation of foreign authorities. *Operation Millennium* is an example of a successful SOD operation. On October 13, 1999, Colombian National Police arrested fourteen individuals in Bogota, one in Cali, and fifteen in Medellin. These individuals were all indicted on cocaine and money laundering charges on September 30, 1999, by a federal grand jury in Miami. The U.S. has formally sought their extradition, as well as the extradition of a Colombian national arrested in Mexico by Mexican officials.

Operation Southwest Express, another SOD case, targeted a Mexican trafficking organization, based in Ciudad Juarez, Mexico, and Mexican transportation groups used by this organization to transport cocaine and marijuana to the U.S. This investigation identified a Mexican drug distribution network operating in Chicago, New York, and San Diego and other distribution networks operating in Boston, Cleveland, New York, Houston, Nashville, Chicago, and Atlanta. The DEA, FBI, Customs, INS, IRS, numerous state and local law-enforcement offices, as well as twelve U.S. Attorney's Offices, and Criminal Division attorneys were involved in the investigations that resulted in the arrests of more than 100 defendants in August 1999.

Assisting State and Local Agencies

The Department of Justice has adopted a two-pronged approach to help state and local communities. First, DOJ provides funding and technical assistance to law-enforcement agencies at all levels. Second, DOJ funds initiatives by promoting testing and treatment for offenders, thus helping communities offer employment opportunities and prevent drug abuse.

The U.S. Attorney, as chief federal law-enforcement officer in each judicial district and the Department of Justice as a whole, works with state and local law-enforcement agencies to develop priorities, implement strategies, and supply leadership. DOJ assists communities and neighborhoods through the Edward Byrne Memorial State and Local Law Enforcement Assistance Program. Grants support multi-jurisdictional task forces, demand-reduction education involving police officers, and other activities directly related to preventing drug-related crime and violence. The local Law Enforcement Block Grant Program contributes funds for hiring police, improving school safety, purchasing equipment, and setting up multi-jurisdictional task forces. Major national coordination programs include:

High Intensity Drug Trafficking Area (HIDTA)

HIDTAs are regions with critical drug trafficking problems that harm other areas of the United States. The ONDCP director – in consultation with the Attorney General, Secretary of Treasury, heads of drug control agencies, and appropriate governors – designates these

locations. There are currently thirty-one HIDTAs. In addition to coordinating drug-control efforts, HIDTAs assess regional drug threats, develop strategies to address the threats, integrate initiatives, and provide federal resources to implement initiatives. HIDTAs strengthen America's drug-control efforts by forging partnerships among local, state, and federal law-enforcement agencies; they facilitate cooperative investigations, intelligence sharing, and joint operations against drug-trafficking organizations. The Department of Defense gives priority support to HIDTAs in the form of National Guard assistance, intelligence analysts, and technical training. In 1999, the director of ONDCP designated selected counties in the following areas as HIDTAs: Central Valley California, Hawaii, New England, Ohio, and Oregon.

The HIDTA program advances the National Drug Control Strategy by providing a coordination "umbrella" for agencies to combine anti-drug efforts through an outcome-focused approach. The resulting synergy eliminates unnecessary duplication of effort, maximizes resources, and improves information sharing within and between regions. Intelligence is coordinated at HIDTA Investigative Support Centers, which offer technical, analytical, and strategic support to participating agencies with access to agency databases and supplemental personnel. Currently, 949 local, 172 state, and thirty-five federal law-enforcement agencies and eighty-six other organizations participate in 462 HIDTA-funded initiatives.

Community-Oriented Policing

Community-Oriented Policing is an innovative crime-fighting strategy which recognizes that neighborhood problems can be solved best when police and community work together. This collaboration between civilians and officers has successfully decreased drug-related crime. The Office of Community Oriented Policing Services (COPS) advances policing of anti-drug actions at the street level. It has funded the addition of over 100,000 community police officers to the beat. The COPS Office supports four drug-related grant programs: (1) a Methamphetamine Initiative that combats production, distribution, and use (2) the COPS Technology Program, which deploys the Southwest Border States Anti-Drug Information System; (3) School-Based Partnerships that encourage law-enforcement agencies to work with schools and community-based organizations against crime; and (4) the Distressed Neighborhood Pilot Project in eighteen cities that face particularly high crime rates. Building on the successful COPS initiative, the President has proposed a new twenty-first Century Policing Initiative to help communities hire, redeploy, and retain thirty-thousand to fifty-thousand additional community policing officers, acquire the latest crime-fighting technologies, and engage the entire community in anti-crime measures.

Organized Crime Drug Enforcement Task Forces (OCDETF)

The most effective way to attack sophisticated drug-trafficking organizations and attendant criminal activity — like money laundering, corruption, violence, organized crime, and tax evasion — is through coordinated, inter-agency task-forces. Accordingly, the Department of Justice calls upon the OCDETF program, with its nine federal law-enforcement agencies, to employ a wide range of expertise in disrupting and dismantling drug-trafficking organizations. The collaboration between law enforcement and U.S. Attorneys, as well as state and local district attorneys and attorneys general, plays an integral part in OCDETF's fight against drug traffickers. In 1998, OCDETF initiated 1,356 investigations with 2,447 indictments returned (more than double the number during the previous two years combined, with a 41.6 percent increase in indictments).

In 1999, OCDETF had the single most productive year in its history — initiating over 1400 investigations against the nation's most serious drug trafficking organizations. On September 20, 1999, five members of the drug trafficking organization known as the Seventh Ward Soldiers were each sentenced to life in prison, plus additional time of 5-20 years, following their jury convictions for marketing crack cocaine and murdering and shooting other drug dealers and witnesses. Police records indicate that since these gang members were taken into custody, the community they previously terrorized has experienced a 42 percent decrease in the number of shootings and 42.8 percent decrease in the murder rate.

Weed and Seed

This flagship neighborhood-based program is a multi-disciplinary approach to combating crime. Present in 176 sites across the nation under the leadership of U.S. Attorneys, this program brings together federal, state, and local crime-fighting agencies, social service providers, representatives from the public and private sector, prosecutors,

business owners, and neighborhood residents. Weed and Seed sites implement programs to reduce drug-trafficking in particular geographic areas, e.g. campaigns to investigate and prosecute individuals involved in methamphetamine manufacture and sales (Salt Lake City, Utah), cocaine distribution (Las Vegas, Nevada and Galveston, Texas), and trafficking in crack and powder cocaine, marijuana, and heroin (Tampa, Florida). In Seattle, violent crime in the Weed and Seed area dropped 54 percent between 1991 and 1996 while crime city-wide decreased only 38 percent. In Hartford, Connecticut the number of violent crimes in the Weed and Seed target area decreased 46 percent in 1996 compared to 1994 – the year before Weed and Seed was started. During the same period, city-wide crime declined only 22 percent. In Las Vegas, serious crime in the target area dropped 8 percent between 1993 and 1996 while city-wide crime decreased 3 percent.

Anti Money-Laundering Initiatives

Illicit drug trafficking produces billions of dollars in income domestically and internationally. The success of drug-traffickers, and organized crime in general, is based largely upon the ability to launder their criminal proceeds. Through money laundering, the criminal transforms illegal proceeds into funds with a seemingly legal source. This process can have devastating social and economic consequences. Criminals manipulate financial systems in the United States and abroad to promote a wide range of illicit activities. Left unchecked, money laundering can erode the integrity of financial institutions, cause greater volatility in foreign exchange markets, destabilize economies, place honest businesses at comparative disadvantage, undermine public trust, erode democratic institutions, and breed violence. The Department of Treasury, Department of Justice, Postal Inspection Service, Internal Revenue Service, federal regulators, and state and local law enforcement work in an integrated manner to target specific sectors of the financial system, susceptible or vulnerable to financial criminal activity.[48]

In light of the threat to national security concerns posed by money laundering, Congress passed the Money Laundering and Financial Crimes Act of 1998, which calls for the development of a five-year anti-money laundering strategy. In September 1999, the Departments of Treasury and Justice responded by releasing the first National Money Laundering Strategy (NMLS). This document, and its subsequent annual reports, provides a comprehensive overview of all U.S. government efforts to combat the subversion of our monetary system. Secretary of the Treasury Lawrence Summers and Attorney General Janet Reno call the NMLS "a new stage in the government's fight against money laundering." The NMLS calls for: (1) designating high-risk money laundering zones where coordinated law-enforcement efforts can be concentrated; (2) focusing attention on suspicious activities across the range of financial institutions; (3) implementing the Money Laundering Act of 1999 to bolster domestic and international enforcement; (4) reviewing measures to restrict the use of accounts in the United States by offshore institutions that pose a money-laundering risk; and (5) intensifying pressure on nations that lack adequate controls to counter money laundering. This strategy entails an enhanced level of coordination and cooperation among government agencies and between the private and public sectors. The Department of Treasury's Financial Crimes Enforcement Network (FinCEN) serves, with growing sophistication, as the principal center for strategic analysis and investigative support for efforts aimed at narcotics-related financial crimes.

To assist further in the fight against money laundering, banks are required to report financial activity they suspect involves funds derived from criminal activity.[49] This information is placed in a secure database co-owned by the primary bank and credit union regulators and administered by the Department of the Treasury. High priority has been given to the problems raised by criminal abuse of a group of financial service providers known collectively as "money services businesses" (MSBs).[50] In August 1999, a ruling that announced the registration of MSBs was finalized. Over the next year, the Department of the Treasury will be extending mandatory suspicious reporting to other financial service provider sectors vulnerable to money laundering, including money service businesses like money-wire transmitters, "casas de cambio," and sellers of money orders and travelers' checks. Thereafter, suspicious reporting will be extended to casinos, brokers, and dealers.

DOJ's Special Operations Division (SOD) has formed a Money Laundering Section, which is comprised of senior agents and analysts from Customs, DEA, FBI, and IRS, and supported by attorneys from DOJ's Criminal Division. This section will support and coordinate drug-related money laundering and financial investigations conducted by federal, state, and local law enforcement in coordination with United States Attorneys' Offices. The section is

designed to comprehensively attack domestic and foreign drug-trafficking organizations and their money laundering elements.

Treasury's Money Laundering Coordination Center (MLCC) is another example of interagency collaboration and support to money laundering investigations and prosecution. The MLCC was created through collaborative effort between the U.S. Customs Service and the FinCEN and is housed at FinCEN. With agents and analysts from USCS, DEA, FBI, IRS, OFAC, and USPS, the MLCC serves as repository for all intelligence information gathered through undercover money laundering investigations and functions as a coordination and deconfliction center for both domestic and international undercover money laundering operations. Additionally, the Treasury Department created the National Center for State and Local Enforcement Training, located at the Federal Law Enforcement Training Center (FLETC) in Glynco, GA, to share Federal experience, resources, and expertise in fighting money laundering activities.

Enhancing Asset Forfeiture

The Department of Justice and Department of Treasury use asset forfeitures to attack the economic infrastructure of drug-trafficking organizations and money-laundering enterprises. Both strategically integrate this tool into their overall enforcement plan to strike traffickers at the source of their power. Asset forfeiture is part of the department's Southwest Border Initiative. In FY 1998, *Operation Magnolia* trafficker Luis H. Cano consented to a twenty-eight million dollar forfeiture judgment. *Operation Kids* in Puerto Rico resulted in defendants being found liable for the forfeiture of 4.1 million dollars in drug-related assets.

Treasury Bureaus incorporate seizure and forfeiture of assets belonging to narcotics organizations as an integral segment of their comprehensive attack on narcotics organizations. Their goal is to deny the organization the wherewithal to continue operations and ensure its total dismemberment. Federal, state, local, and foreign law enforcement agencies work together to follow the "money trail" wherever it may lead. In a joint investigation of the largest and longest operating Thai marijuana smuggling group in Oregon, IRS-CI, USCS, DEA, and Swiss authorities were able to seize $11.7 million from a single drug trafficker. In FY 1999, IRS-CI alone sized in excess of $80 million and through the Treasury Asset Forfeiture Fund shared $19.5 million with foreign, federal, state, and local agencies. The Equitable Sharing Program law-enforcement cooperation by dividing the proceeds of a forfeiture among agencies that participated in the investigation. During FY 1998, DOJ worked with nearly three-thousand agencies that took part in this program.

Preventing Chemical Diversion

Precursor and essential chemicals are crucial for manufacturing most illicit drugs sold in the United States. Two DOJ initiatives target chemical distributors involved in diverting chemicals to the illicit marketplace. *Operation Backtrack* targets "rogue" chemical companies that sell methamphetamine precursor chemicals without adhering to federal regulations and international protocols. Since its inception in February 1997, this initiative resulted in 146 arrests, seizure of 9.6 million dollars in assets, and confiscation of chemicals that could have been used to produce 9,400 pounds of methamphetamine. In FY 1998, regulatory controls by the DEA prevented the diversion of 49.95 tons of ephedrine and fourteen tons of pseudoephedrine. The California Precursor Committee (CPC), chaired by the U.S. Attorney's Office in San Diego, and involving all four U.S. Attorneys in California and more than twenty federal, state, and local agencies in California and neighboring states, coordinates an effort to reduce the availability of precursor chemicals through investigation and prosecution of methamphetamine chemical suppliers. Since inception of the CPC, dozens of investigations and prosecutions against rogue chemical suppliers within California and out-of-state have occurred. In an eighteen month period ending in early 1999, California chemical cases resulting in convictions netted the seizure of approximately nine hundred kilograms of pseudoephedrine tablets, two million ephedrine tablets, 21,000 gallons of freon, 30,000 pounds of iodine, 4,000 pounds of red phosphorus, and in excess of 2,000 pounds of hydrogen chloride gas. The efforts of the CPC have recently been expanded through the HIDTA-supported National Methamphetamine Chemicals Initiative which has sponsored the training of over one hundred federal prosecutor, and will sponsor training of hundreds of agents, investigators, and inspectors in the methods of investigating and ferreting out rogue chemical suppliers.

Intelligence/Information Sharing

Intelligence gleaned from the collection, evaluation, analysis, and synthesis of information must be shared in order to reduce cultivation, production, trafficking, and distribution of drugs. Cooperation in sharing and deconflicting strategic and operational intelligence is critical for combating the international and domestic drug problem. Tactical intelligence is time-sensitive and crucial to the execution of arrests and seizures. Agencies must be able to share relevant information across jurisdictional boundaries without risk of compromise to intelligence and the operations that derive from it.

Under the Border Coordination Initiative (BCI), personnel from the U.S. Customs Service, the Immigration and Naturalization Service, and the Border Patrol have been co-located into Intelligence Collection Analysis Teams along the Southwest border to gather and disseminate tactical intelligence. DOJ's Regional Information Sharing System consists of a network of centers that jointly process intelligence on drug trafficking, violent crime, gang activity, and organized crime. In FY 1999, this network contributed to the arrest of 4,160 individuals and the seizure of drugs valued at 104 million dollars. The HIDTA program establishes Information Support Centers in designated areas specifically to create a communication infrastructure that can facilitate information-sharing between federal, state, and local law-enforcement agencies. Additional developments in counterdrug intelligence sharing are discussed in Section Five of this chapter.

ONDCP's Counterdrug Technology Assessment Center

Technology can play a dramatic role in combating drug-related crime. Law-enforcement agencies increase their effectiveness by integrating technology and coordinating operations. ONDCP's Counterdrug Technology Assessment Center (CTAC) was established by the Counter-Narcotics Technology Act of 1990 (P.L. 101-510). CTAC is the federal government's drug-control research and development organization. It coordinates the activities of twenty federal agencies. CTAC identifies short, medium, and long-term scientific and technological needs of drug-enforcement agencies — including surveillance; tracking; electronic support measures; communications; data fusion; and chemical, biological, and radiological detection.

CTAC research supports law enforcement in such areas as drug detection, communications, and surveillance. CTAC conducts an array of operational tests and activities to evaluate off-the-shelf and emerging technology prototypes for use in the field. In 1998, Congress authorized a technology transfer program (TTP) for CTAC to provide these technologies to state and local law-enforcement.[51] During its firts eighteen months, CTAC's technology transfer program has provided 892 systems to 631 agencies across the country. Since nighttime counterdrug operations are especially dangerous for officers and undercover narcotics agents, many of the technologies requested by law enforcement have dealt with improved officer safety through more reliable communications and night-vision systems.

The companion volume to this annual report — *Counterdrug Research and Development Blueprint Update* — reviews CTAC's research agenda in support of efforts to reduce the availability and abuse of drugs. It also assesses the effectiveness of federal technology programs aimed at improving drug-detection capabilities used in interdiction and at ports-of-entry.

Targeting Gangs and Violence

The Department of Justice — through the FBI, DEA, USMS, United States Attorneys' office, and Criminal Division along with state and local law-enforcement counterparts — is focusing on identifying, disrupting, and dismantling criminal gangs. Available tools include the application of federal racketeering statutes, federal and state narcotics and weapons laws, and collaborative multi-agency task forces. DOJ's Anti-Violent Crime Initiative, which targets gangs and violent crime, has reduced drug trafficking substantially. Gangs are involved in the national distribution of drugs and frequently use automatic weapons.

The DEA and FBI lead federal efforts to break up trafficking organizations. The FBI's National Gang Strategy is the framework for combating such violence in America. In 1998, for example, the FBI — in conjunction with the New York Police Department and the Office of the Inspector General of the Department of Housing and Urban Development — targeted the Almighty Latin King and Queen Nation. This organization was involved in violent criminal activity, including murder, robbery, and drug and weapons trafficking. The FBI established 166 Safe Street task forces to address violent crime, much of which is drug related. In early 1995, DEA launched the

Mobile Enforcement Team (MET)* program to assist state and local police in combating the problem of drug-related crime. METs have been established in all but one of DEA's field offices and are deployed in diverse communities throughout the country. The Department of Justice is using the National Gang Tracking Network, a comprehensive computer database that keeps tabs on gang members operating across state lines.

The Bureau of Alcohol, Tobacco, and Firearms (ATF) targets armed drug traffickers through the Achilles Program, which oversees task forces in jurisdictions where drug-related violence is severe. The ATF also conducts Gang Resistance Education and Training (G.R.E.A.T.) in schools. Since 1992, more than two million children received G.R.E.A.T. instruction.

Equitable Sentencing Policies

The Administration supports revision of the 1986 federal law that mandates a minimum five-year prison sentence for anyone possessing either five hundred grams of powder cocaine or a mere five grams of crack cocaine. This law, which punishes crack cocaine involvement one hundred times more severely than powder cocaine crimes, is problematic for two reasons. First, since crack is more prevalent in black, inner-city neighborhoods, the law has fostered a perception of racial injustice in our criminal justice system. In fact, 90 percent of those convicted on crack cocaine charges are African American. Second, harsher penalties for crack possession compared to powder have resulted in long incarceration for low-level crack dealers instead of increased apprehension of middle and large-scale cocaine traffickers.

The Administration recommends that federal sentencing treat crack as ten times worse than powder, not one hundred times worse. Specifically, the amount of powder cocaine required to trigger a five-year mandatory sentence would be reduced from five hundred to two hundred and fifty grams while the amount of crack cocaine required to trigger the same sentence would increase from five grams to twenty-five grams. This difference would reflect – without gross exaggeration – the greater addictive potential of crack (which is smoked) compared to powder (when snorted), the greater violence associated with the trafficking of crack cocaine, and the importance of targeting mid and higher-level traffickers as opposed to smaller-scale dealers. The Administration also recommends that mandatory minimums be abolished for simple possession of crack. Among all controlled substances, crack is the only one with a federal mandatory minimum sentence for a first offense of simple possession.

Community support is critical to the success of law enforcement. When people lose confidence in the fairness and logic of the law – as has been the case with the 1986 statute – law-enforcement suffers. By revising the inequitable sentencing structure for powder versus crack cocaine, the Administration intends to restore overall respect for the law and foster a more effective division of responsibility between law-enforcement authorities.

State Drug Laws

State laws are an important vehicle for translating the concepts in the *National Drug Control Strategy* into action. The *Strategy's* policies are embodied within a tangible legislative framework with which state policymakers shape policies and laws. With this goal in mind, Congress in 1988 mandated the creation of a bipartisan commission to develop state drug laws. The resulting President's Commission on Model State Drug Laws drafted forty-four drug and alcohol laws and policies covering enforcement, treatment, education, prevention, intervention, employment, housing, and community issues.

Since 1996, the Commission's non-profit successor – the National Alliance for Model State Drug Laws – has been conducting state model law workshops. These workshops brought together hundreds of diverse participants on the state level who recommended more than a hundred pieces of drug and alcohol legislation, programming, funding, and coordination initiatives. With these recommendations, state and local leaders have adopted new statutes, formed more effective multi-disciplinary partnerships, and streamlined legislative and programmatic applications.

* The MET program helps local authorities attack violent drug organizations by: 1) identifying major drug-traffickers who commit homicide and other violent crimes; 2) collecting, analyzing, and sharing intelligence with state and local counterparts; 3) conducting investigations against violent drug offenders and gangs; 4) arresting drug traffickers and assisting in the arrest of violent offenders; 5) seizing the assets of violent drug-offenders; 6) supporting state and local prosecutors.

SHIELDING U.S. BORDERS FROM THE DRUG THREAT

Borders delineate the sovereign territories of nation-states. Guarding our country's 9,600 miles of land and sea borders is one of the federal government's most fundamental responsibilities – especially in light of the historically open, lengthy borders with our northern and southern neighbors. The federal government maintains three hundred ports-of-entry, including airports where officials inspect inbound and outbound individuals, cargo, and conveyances. All are vulnerable to the drug threat. By curtailing the flow of drugs across our borders, we reduce drug availability throughout the United States and decrease the negative consequences of drug abuse and trafficking in our communities.

In FY 1999, more than seventy-five million passengers and crew members arrived in the United States aboard commercial and private aircraft. Some nine million came by marine vessels and 395 million through land border crossings. People entered America on 200,000 ships; 900,000 aircraft; and 135 million trucks, trains, buses, and automobiles. Cargo arrived in sixteen million containers. This enormous volume of movement makes interdiction of illegal drugs difficult.

Even harder is the task of interdicting drug trafficking in cargo shipments because of the ease with which traffickers can switch modes and routes. Containerized cargo has revolutionized routes, cargo tracking, port development, and shipping companies. A recent study by the Office of Naval Intelligence indicated that over 60 percent of the world's cargo travels by container. Moreover, the use of intermodal containers by vessels carrying as many as six thousand containers – which have the ability to offload cargo onto rail or trucks at various ports-of-entry and then transport it into the heart of the United States – further complicates the interdiction challenge. Drug-trafficking organizations take advantage of these dynamics by hiding illegal substances in cargo or secret compartments. False seals have been used on containers so that shipments can move through initial ports-of-entry unimpeded. To counteract this threat, the federal government is constantly seeking new technologies which, together with capable forces and timely intelligence, facilitate a well-coordinated interdiction plan responsive to changing drug-trafficking trends.

Organizing Against the Drug Threat

The U.S. Customs Service has primary responsibility for ensuring that all cargo and passengers moving through ports-of-entry comply with federal law. Customs is the lead agency for preventing drug trafficking through airports, seaports, and land ports-of-entry. Customs shares responsibility for stemming the flow of illegal drugs into the United States via the air and sea. It accomplishes this mission by detecting and apprehending drug-smuggling aircraft and vessels trying to enter the country. The Customs' Air and Marine Interdiction Division provides seamless twenty-four-hour radar surveillance along the entire southern tier of the United States, Puerto Rico, and the Caribbean using a wide variety of civilian and military ground-based radar, tethered aerostats, reconnaissance aircraft, and other detection sensors. In fiscal year 1999, Customs seized 1,309,863 pounds of marijuana, cocaine, and heroin – a 17.4 percent increase over seizures in FY 1998.

The U.S. Border Patrol specifically focuses on drug smuggling between land ports of entry. In FY 1999, the Border Patrol seized 514,659 kilograms of marijuana, 11,180 kilograms of cocaine, forty-five kilograms of heroin, and 215 kilograms of methamphetamine. In addition, the Border Patrol made 6,402 arrests of suspected traffickers in areas other than ports-of-entry.

The Coast Guard is the lead federal agency for maritime drug interdiction and plays a key role in protecting our borders. It shares responsibility for air interdiction with the U.S. Customs Service. All our armed forces provide invaluable support to law-enforcement agencies involved in drug-control operations, particularly in the Southwest border region.

Trafficking across the Southwest Border

In 1999, 295 million people, eighty-eight million cars, four million trucks, and 461,000 rail cars entered the United States from Mexico. More than half of the cocaine on our streets and large quantities of heroin, marijuana, and methamphetamine come across the Southwest border. Illegal drugs are hidden in all modes of conveyance – car, truck, train, and pedestrians. Drugs cross the desert in armed pack trains as well as on the backs of human "mules." They are tossed over border fences and then whisked away on foot or by vehicle. Operators of

ships find gaps in U.S./Mexican interdiction coverage and position drugs close to the border for eventual transfer to the United States. Small boats in the Gulf of Mexico and eastern Pacific seek to deliver drugs directly to the United States. Whenever possible, traffickers try to exploit incidences of corruption in U.S. border agencies to facilitate drug smuggling. It is a tribute to the vast majority of dedicated American officials that integrity, courage, and respect for human rights overwhelmingly characterize their service. Rapidly growing commerce between the United States and Mexico complicates the attempt to keep drugs out of cross-border traffic. Since the Southwest border is currently the most porous part of the nation's periphery, we must mount a determined effort to stop the flow of drugs there. At the same time, we cannot concentrate resources along the Southwest border at the expense of other vulnerable regions because traffickers follow the path of least resistance and funnel drugs to less defended areas.

Five principal departments – Treasury, Justice, Transportation, State, and Defense – are concerned with drug-control issues along the Southwest border. These agencies have collaborated in six drug-control areas – drug interdiction, anti-money laundering, drug and immigration enforcement, prosecutions, counter-drug support, and counter-drug cooperation with Mexico. During the past decade, the federal presence along the Southwest border expanded. Customs' budget for Southwest border programs increased 72 percent since FY 1993. The number of assigned DEA special agents increased 37 percent since FY 1990. The number of assigned INS agents almost doubled since FY 1990. DoD's drug-control budget for the Southwest border increased 53 percent since FY 1990. The number of U.S. attorneys handling cases there went up by 80 percent since FY 1990. The Southwest Border Initiative enabled federal agencies to coordinate intelligence and operational assignments at Customs, DOJ's Special Operations Division, HIDTA, and state and local law-enforcement agencies.

The United States Coast Guard plays a critical role in protecting the maritime flanks of the Southwest Border. "Operations Border Shield" and "Gulf Shield" protect the coastal borders of Southern California and along the Gulf of Mexico from maritime drug smuggling with USCG air and surface interdiction assets. The Coast Guard operations are coordinated, multi-agency efforts that focus on interdiction to disrupt drug trafficking.

All Borders

We must stop drugs everywhere they enter our country – through the Gulf Coast, Puerto Rico, the U.S. Virgin Islands, Florida, the northeastern and northwestern United States, or the Great Lakes. The vulnerability of Alaska, Hawaii, and the U.S. territories must also be recognized. Florida's location, geography, and dynamic growth will continue to make that state particularly attractive to traffickers for the foreseeable future. Florida's six hundred miles of coastline render it a major target for shore and airdrop deliveries in the 1980s. The state is located astride the drug-trafficking routes of the Caribbean and Gulf of Mexico. The busy Miami and Orlando airports and Florida's seaports – gateways to drug-source countries in South America – are used as distribution hubs by international drug rings. To varying degrees, Florida's predicament is shared by other border areas and entry points. As we focus on specific parts of our borders, we must anticipate activities elsewhere. In the end, we need to shield all U.S. borders from the flow of illegal drugs.

DOJ's Southern Frontier Initiative focuses law enforcement on drug-trafficking organizations operating along the Southwest border and the Caribbean. "Operation Trinity" resulted in 1,260 arrests, including eight hundred members of the five largest drug syndicates in Mexico and Colombia. DOJ's Caribbean Initiative substantially enhanced its counterdrug capabilities in this region, with more law enforcement agents, greater communications, and improved interception. In fiscal year 1999, USCG "Operation Frontier Shield" seized eighteen vessels in its efforts to disrupt drug smuggling into Puerto Rico and the U.S. Virgin Islands – a three-fold increase from 1998.

Organizing for Success

The problems law-enforcement officials face in connection with illegal drugs are significant but not insurmountable. Twenty-three separate federal agencies and scores of state and local governments are involved in drug-control efforts along our borders, air, and seaports. The Interdiction Committee (TIC), led by the Commissioner of U.S. Customs and comprised of the leads of drug law enforcement agencies, is working on a review of coordination among federal agencies responsible for anti-drug operations (the Arrival Zone Interdiction Plan). This review is initially focussed on the Southwest border.

A review of the counterdrug intelligence architecture concluded that clear, consistent inter-community and inter-agency coordination is essential. To this end, the *General Counterdrug Intelligence Plan* (GCIP) strengthens the El Paso Intelligence Center.

Border Coordination Initiative (BCI)

To improve coordination along the land borders of the United States, the Departments of Justice and Treasury – along with other agencies with border responsibilities – established the Border Coordination Initiative (BCI). Organized as a five-year program and initially emphasizing the Southwest border, BCI is helping to create integrated border management to improve the effectiveness of this joint effort. It emphasizes increased cooperation to support the interdiction of drugs, illegal aliens, and other contraband while maintaining the flow of legal immigration and commerce. BCI plans call for:

Port Management — A Customs and INS Port Management Model that will streamline enforcement, traffic management, and community partnership at each of the SWB's twenty-four POEs.

Investigations — A unified strategy for SWB seizures that capitalizes on investigative operations and the dissemination of intelligence to enhance inspections. The Department of Justice's Narcotics and Dangerous Drug Section continues to support the Southwest Border Initiative by prosecuting major drug-trafficking cases along the Southwest border. For example, in an ongoing OCDETF case in the Southern District of California, sixteen defendants were charged with conspiracy to import and distribute more than 1000 kilograms of marijuana and multiple kilograms of cocaine. The lead defendant is a helicopter pilot and former Mexican police official. The property subject to forfeiture includes a 1965 Bell helicopter, a 38 foot yacht, and residential property valued in excess of $400,000.

Intelligence Joint Intelligence Collection Analysis Teams (ICATs) — comprised of personnel from Customs, Immigration and Naturalization, and the Border Patrol – are collecting and disseminating tactical intelligence in regard to drug interdiction, illegal aliens, money laundering, and document fraud.

Technology — A joint plan to capitalize on future technological advances while making better use of existing capabilities.

Communications — Inter-operable, secure, mutualy supportive, wireless communications through coordinated fielding, user training, compatible systems, and shared frequencies. USCS is already 100 percent secure with over-the-air rekeying and is working to achieve total voice privacy with the Border Patrol and all other participating agencies.

Aviation and Marine — Joint air interdiction operations and the identification of opportunities to share air and marine support facilities.

Port and Border Security Initiative

This initiative seeks to reduce drug availability by preventing the entry of illegal substances into the United States. The initiative covers all U.S. ports-of-entry and borders but focuses on the Southwest border. Over the next five years, this initiative will result in appropriate investments in Immigration and Naturalization Service (INS) inspectors and Border Patrol agents, Customs' agents, analytic, and inspection staff, improved communication and coordination between Customs and INS, employment of advanced technologies and information management systems, and greater U.S.-Mexico cooperation.

Working with the Private Sector to Keep Drugs Out of America

Agreements with the private sector can deter drug smuggling via legitimate commercial shipments and conveyances. As the primary drug-interdiction agency at ports of entry, the U.S. Customs Service is implementing programs like the air, sea, and land Carrier Initiative Programs (CIP), the Business Anti-Smuggling Coalition (BASC), and the Americas Counter-Smuggling Initiative (ACSI) to keep illegal drugs out of licit commerce. These initiatives have resulted in the seizure of 215,000 pounds of drugs since 1995.

Harnessing Technology

Technology is an essential component in the effort to prevent drug smuggling across our borders and via passenger and commercial transportation systems. Intelligence-based information systems provide Customs inspectors with information on suspicious shipments. Customs P-3 aircraft are used as airborne test platforms for military and commercial sensor equipment with counterdrug applications. USCS is also deploying advanced non-intrusive inspection technologies developed in conjunction with Department of Defense and CTAC to inspect luggage, cars, and shipments from pallet-

sized items up to large marine containers for concealed drugs at ports of entry. A dedicated breeding program for substance-detecting canines has been developed based upon a cooperative effort with Australian customs. Canines derived from this program are being placed at key ports-of-entry.

Technology can prevent trafficking between ports-of-entry. The Immigration and Naturalization Service's Integrated Surveillance Information System/Remote Video Surveillance (ISIS/RVS) project, for example, is improving the Border Patrol's effectiveness along the Southwest border.

Review of Counterdrug Intelligence Architecture

An extensive interagency review of counterdrug intelligence was commissioned in 1997 by the Attorney General, the Director of Central Intelligence (DCI), the Secretary of the Treasury, and the Director of National Drug Control Policy, supported by the Secretaries of Defense, Transportation, and State. The Review, initiated by a White House Task Force (WHTF), was mandated in the Treasury and General Government Appropriations Act of 1998 and the 1998 Intelligence Authorization Act. According to the WHTF report, counterdrug investigative information and intelligence sharing has improved over the past several years. Despite laudable achievements, boundaries between various law enforcement and intelligence components produce gaps in coverage as well as incomplete or inaccurate analysis, unnecessary duplication, single-agency perceptions of critical drug threats or issues, and occasional mistrust or confusion in the counterdrug community.

The Administration's General Counterdrug Intelligence Plan (GCIP) establishes a framework to support field operators; improve counterdrug relationships; and respond to policymakers as they formulate counterdrug policy. For the first time, the GCIP has created a permanent coordination mechanism to resolve drug intelligence issues and aid national agencies in satisfying performance measures of effectiveness. The GCIP facilitates the appropriate and timely exchange of information between the intelligence and drug law enforcement communities.

REDUCING THE SUPPLY OF ILLEGAL DRUGS

Supply reduction is an essential component of a well-balanced strategic approach to drug control. When illegal drugs are readily available, the likelihood increases that they will be abused. Supply reduction has both domestic and international dimensions. Within the United States, supply reduction includes regulation (through the Controlled Substances Act), enforcement of anti-drug laws, eradication of marijuana cultivation, control of precursor chemicals, inspection of commerce and persons entering the country, screening for drugs in prisons, and the creation of drug-free school zones. Internationally, supply reduction includes building consensus; bilateral, regional, and global accords; coordinated investigations; interdiction; control of precursors; anti-money-laundering initiatives; drug-crop substitution and eradication; alternative development; strengthening public institutions; and foreign assistance.

Interdiction Operations

Despite our best efforts, we will never seize all drugs that arrive at our borders or air and seaports. Drug traffickers are adaptable and react to interdiction successes by shifting routes and modes of transportation. International drug organizations also have access to sophisticated technology to support their crimes. The United States Interdiction Community must be adaptable to this ever-changing threat.

The U.S. government designs coordinated interdiction operations that anticipate shifting drug-trafficking patterns. These integrated actions are led by the two Joint Inter-Agency Task Forces (JIATF-East based in Key West, FL and JIATF-West in Alameda, CA) that coordinate transit zone activities; the Customs' Air and Maritime Interdiction Coordination Center (in Riverside, CA) that monitors air approaches to the United States; and the El Paso, Texas-based Joint Task Force Six and Operation Alliance that coordinate activities along the Southwest border. The current U.S. Interdiction Coordinator, who is responsible for efficiently deploying and integrating the U.S. assets committed to international interdiction effort, is the Commandant of the U.S. Coast Guard.

Several key changes were made in 1999 to the regional counterdrug support architecture of the United States. In May of 1999, JIATF-East added to its set of responsibili-

ties the Source Zone-focused counterdrug support missions previously executed by JIATF South. The merger of JIATF East and JIATF South offers a considerable opportunity for maximizing the efficient operation of these counterdrug missions in the years to come.

JIATF-East counterdrug air detection and monitoring missions are carried out from a number of bases in the continental United States and the Caribbean. Assets previously based out of Howard Air Force Base (AFB), Panama are now operating from three Forward Operating Locations (FOLs) and Forward Operating Sites (FOSs) in the Caribbean and South America. The U.S. government has obtained a long-term agreement with Ecuador to operate from an FOL in their territory. A second FOL, based in the Netherlands Antilles and Aruba, is operating under a temporary agreement. In 2000, the United States expects to sign a long-term FOL agreement with the Kingdom of the Netherlands, ensuring continued detection and monitoring coverage in the region. There is also a tentative plan for a third FOL in Central America. The United States anticipates an increase in the total number of counterdrug detection and monitoring flight hours that previously originated from Howard AFB.[52]

Transit Zone Operations

Drugs coming to the United States from South America pass through a six million square-mile transit zone roughly the size of the continental United States. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations.

The Coast Guard is key to reducing the maritime flow of drugs through the transit zone. Through a strategic plan designed to meet the interdiction performance goals of the *National Drug Control Strategy*, the Coast Guard works to deny smugglers use of maritime routes by concentrating assets and operations in high-threat areas. These forces locate, intercept, stop, and board suspect vessels. A primary force provider for the JIATF force structure, the Coast Guard also deploys Law Enforcement Detachments (LEDETs) aboard ships of the U.S. Navy and international partners in the Caribbean and Eastern Pacific. In 1999, LEDETs were responsible for nearly one-third of Coast Guard cocaine seizures.

"Go-fast" boats* accounted for approximately 70 percent of known maritime smuggling events during fiscal year 1999. The Coast Guard has responded to the threat by acquiring new equipment, developing new capabilities, and changing use-of-force policies. Initial deployments of specially configured helicopters and pursuit boats utilizing a new policy of warning shots and disabling fire was highly successful, resulting in the seizure of 3,014 pounds of cocaine and 3,875 pounds of marijuana in a two month period. Additionally, multinational operations have allowed the Coast Guard to assist Caribbean nations in maintaining regional interdiction efforts through the training of host-nation law enforcement personnel.

In 1999, Customs consolidated its air and marine assets to maximize efficiency and effectiveness in combating the drug smuggling threat in the Western Hemisphere. The Customs Air and Marine Interdiction Division supports all facets of interdiction in the transit zone including intelligence gathering with detection and monitoring aircraft, monitoring a composite of radar and sensor inputs and interdicting suspect aircraft and vessels. In FY 1999, Customs air and marine interdiction assets participated in the seizure of 47,258 kilograms of cocaine, 280,149 kilograms of marijuana, 30 kilograms of heroin, 1,141 kilograms of hashish, 35 aircraft, 60 vessels and 221 vehicles.

The decline in the cocaine trafficking in Jamaica, the Bahamas, and Cuba followed the execution of several joint interdiction operations in the area. There were, however, increases in overall drug trafficking in Haiti, the Dominican Republic, and Puerto Rico as well as smuggling through fishing vessels in the Eastern Pacific. In fiscal year 1999, seventy-eight metric tons of cocaine were seized in the Transit Zone. Coast Guard interdiction efforts in 1999 seized 111,689 pounds of cocaine and 61,506 pounds of marijuana. Cocaine seizures surpassed the previous record of 103,617 pounds set in FY 1997. The retail value of these drugs was estimated at $3.7 billion.

The Department of Defense (DoD) helps reduce the flow of illegal drugs into the United States through command and control, high-tech communications, intelligence sharing, detection, and monitoring. As the

* A "Go-fast" boat is the term used to describe the small, very fast, and difficult to detect vessels favored by drug traffickers.

interagency lead for detection and monitoring, DoD quickly disseminates information gathered by detection platforms through the JIATF structure to the appropriate interdiction agency. Customs is a primary force provider for airborne detection and monitoring missions in support of DoD.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also entails denying traffickers safe haven in countries within the transit zone and preventing the corruption of institutions or financial systems to launder profits. Consequently, international cooperation and assistance is an essential aspect of a comprehensive transit-zone strategy. The United States will continue helping Caribbean and Central American nations to implement a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and backing cooperative interdiction.

Breaking Cocaine Sources of Supply

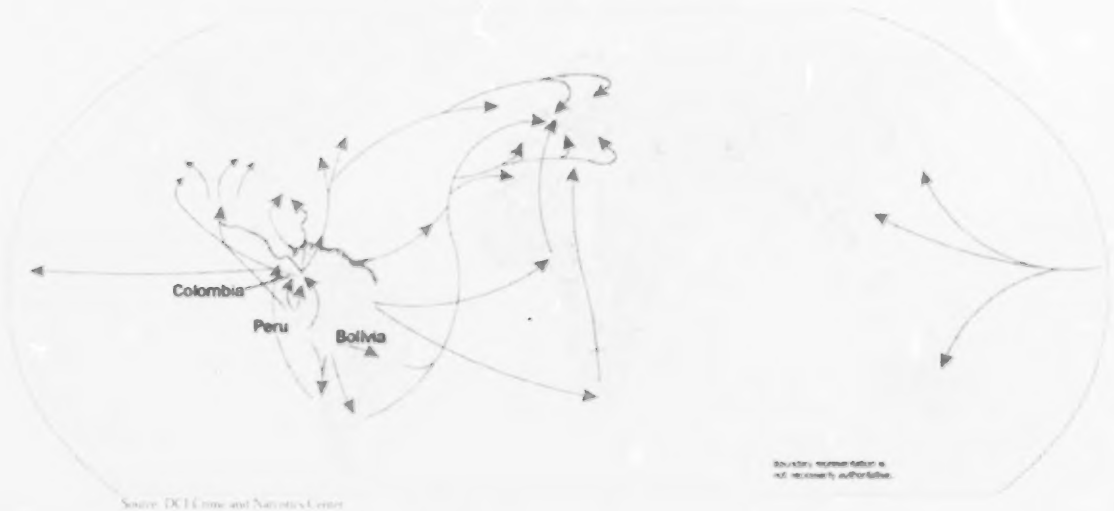
Coca, the raw material for cocaine, is grown primarily in the Andean Region of South America. Dramatic successes in Bolivia and Peru have been tempered by the continued expansion of coca cultivation in Southern Colombia. Despite a more than doubling of the coca crop in Colombia between 1995-1999, successes in the rest of the Andes has reduced global cultivation by 15 percent.[53]

The government of Bolivia achieved a 55 percent reduction in coca cultivation since 1995. An extremely effective eradication program in the principal growing regions surpassed last year's results. In addition, a successful chemical interdiction program forced the remaining Bolivian coca traffickers to rely on inferior substitutes and a less efficient production process, which has reduced the purity of Bolivian cocaine. These actions, combined with an extensive alternative development program, decreases potential cocaine production in Bolivia from 240 metric tons in 1995 to 70 metric tons in 1999.[54] The current Banzer administration continues to make progress towards eliminating all illegal coca from Bolivia by 2002.

However, challenges remain. Coca prices make its cultivation lucrative and disruption of the cocaine industry is incomplete. Although coca growers have committed only sporadic acts of violence and have been unable to create a mass movement to resist eradication efforts, the potential for violence in the Chapare and Yungas growing regions remains a serious concern.

The government of Peru also made enormous strides toward eliminating illegal coca cultivation. Since 1995, Peru achieved a 66 percent reduction in areas under coca cultivation and a corresponding 62 percent drop in cocaine production.[55] This reduction is due to a combination of eradication, law enforcement, and alternative development. In previous years, the Peruvian Air Force directed a successful drug interdiction effort, which

Worldwide Cocaine Flows



Source: DCI Crime and Narcotics Center

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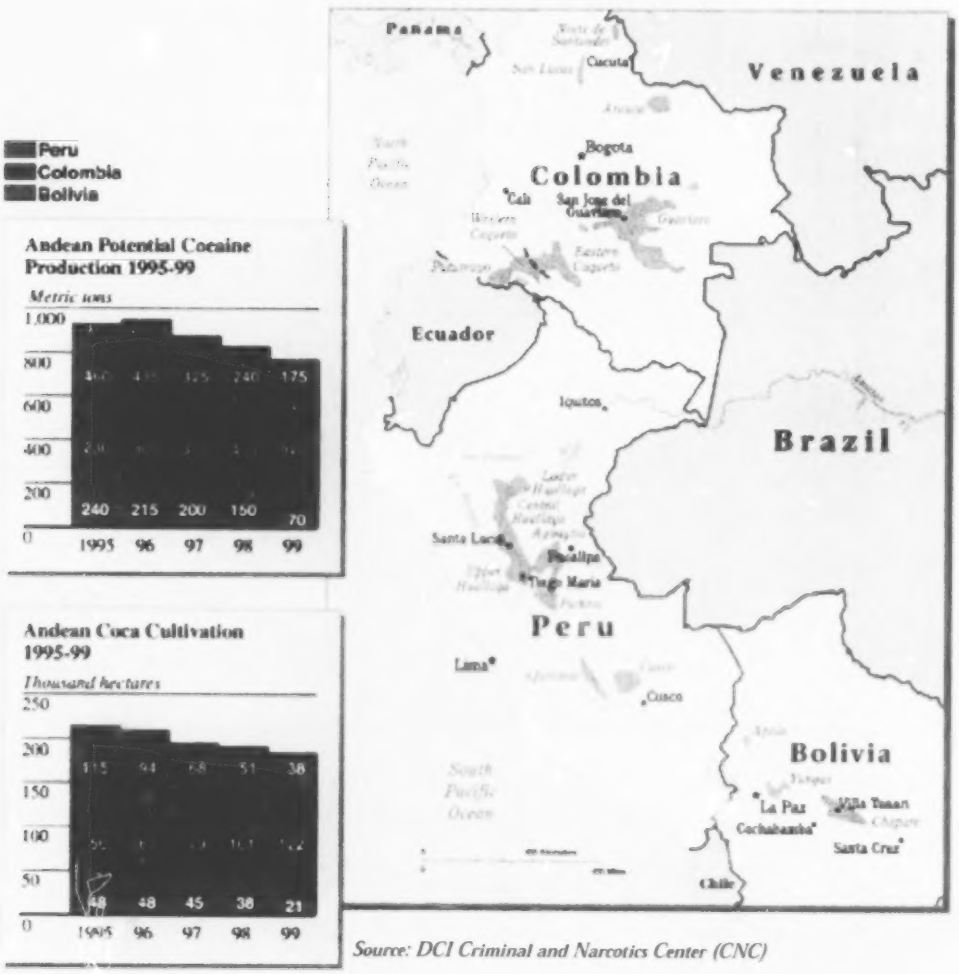
1999 Andean Coca Cultivation



Source: DCI Criminal and Narcotics Center (CNC)

prevented drug crops from reaching secondary markets and disrupted the coca industry in Peru. However, in 1999 air interdiction played a less prominent role as Peruvian cocaine production decreased (resulting in fewer flights) and drug traffickers increased their operational security.

The Fujimori government adjusted its own tactics and augmented its law-enforcement for ground eradication by 350 personnel in 1999. In both Peru and Bolivia, eradicators are using a new tool to pull coca plants out by the roots. This method eliminates coca field rehabilitation efforts. Law-enforcement has constricted the flow of precursor chemical into the growing region, and alternative development efforts provided licit economic opportunities for former coca growers. Despite rising coca leaf prices, Peru achieved a 24 percent reduction in coca cultivation last year.[56]

Some 90 percent of the cocaine that enters the United States originates in or passes through Colombia. Up to six metric tons of heroin are also produced in Colombia annually. Coca cultivation has more than tripled in Colombia since 1992.[57] Colombian traffickers and coca farmers have adopted new cultivation and processing techniques, increasing the amount of drugs processed

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from each acre of crop. Colombia now cultivates two-thirds of the coca leaf grown in the world. If unchecked, the rapid expansion of coca crops and cocaine production in Colombia threatens to increase the global supply of cocaine over the next several years.

Colombia's efforts to attack the drug trade are hampered by guerrillas and paramilitary groups that control the major drug-producing regions. Lack of government presence makes eradication and interdiction difficult and dangerous in most of Colombia's coca-growing regions. The lack of security in southern Colombia prevents the government from implementing alternative development programs.

In addition to armed groups that control large swaths of Colombia's countryside, Colombia's stability is threatened by organized drug mafias that handle international narcotics distribution. The vast amount of money in the hands of these outlaw groups generates violence and corruption. It also threatens Colombia's democratic institutions. The drug threat, violence, and insecurity have compounded the problems associated with Colombia's worst economic recession in seventy years.

The government of Colombia has responded to the problem by increasing law enforcement and eradication efforts in areas accessible to security and police forces. U.S.-supported Colombian efforts have achieved reductions in cultivation in both the Guaviare and Caqueta growing regions. Despite the gains in Guaviare, coca cultivation continues to explode in the Putumayo and northern region of Norte de Santander, remote areas where government anti-drug operations are constrained by large numbers of well-armed and well-organized insurgent forces. The Colombian National Police has disrupted lab production in some areas while leaving the lab infrastructure untouched in regions beyond government control.

In 1998, the Colombian government formed a counter-drug joint task force with elements from all the military services and the National Police. In December 1999, after receiving extensive training from DoD, the first of three planned counterdrug battalions became operational. Supported by U.S.-provided air mobility and a DoD-trained joint military-police intelligence center, these battalions will provide Colombian security forces with a framework for eventually moving into less accessible drug-producing regions in southern and eastern Colombia.

President Andres Pastrana devised a comprehensive, integrated strategy called "Plan Colombia" to address the country's drug and interrelated social and economic troubles. The Colombian government estimates that Plan Colombia – a comprehensive, three-year plan – will cost seven billion dollars. The government of Colombia will fund more than half the cost and wants the United States and the international community to support the additional $3.5 billion dollars.

To assist the government of President Pastrana, the Clinton Administration proposed $1.6 billion in additional aid to Colombia and other source countries over the next two years. The budget proposes to increase assistance programs through an emergency supplemental of $954 million in FY 2000 and $318 million in FY 2001. Funds will be used for Colombian counterdrug efforts and for other programs to help President Pastrana strengthen democracy and promote prosperity. The proposal would enhance alternative development, strengthen the justice system and other democratic institutions, and provide counterdrug equipment, training, and technical assistance to Colombian police and military forces. The Administration is also encouraging U.S. allies and international institutions to assist Colombia in implementing *Plan Colombia*. The budget proposal would also provide additional funding to shore up significant gains against drug production in Peru and Bolivia and prevent the traffickers from simply moving their operations to avoid law enforcement.

The counterdrug strategy in the Source region of southeast Colombia attacks the two strategic vulnerabilities of the cocaine industry: (1) air transportation from the HCL labs east of the Andes to the west and north Colombian coast transshipment regions and (2) the clear susceptibility of coca cultivation to aggressive eradication. Replication in Colombia of the air interdiction results achieved in Peru could mean a dramatic decline in the world's cocaine production.

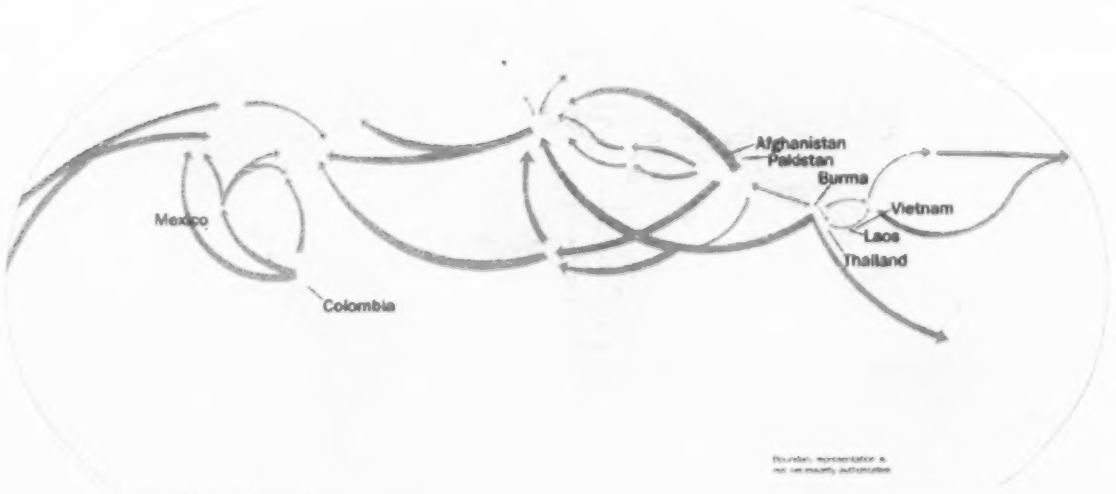
Breaking Heroin Sources of Supply

The U.S. heroin problem is supplied entirely from foreign sources of opium. Efforts to reduce domestic heroin availability face significant problems. Unlike cocaine where the supply is concentrated in the Andean region of South America, heroin available in the United States is produced in four distinct geographical areas: South America, Mexico, and Southeast Asia, and Southwest Asia. Worldwide heroin production was estimated at 313 metric tons in 1998 with between twelve and eighteen metrics tons available for consumption in the United States.[58]

Latin America has emerged in recent years as the primary supplier of heroin to the United States. Although potential production in Latin America stabilized at twelve tons of pure heroin, which accounts for less than 5 percent of worldwide production, Mexican and Colombian heroin comprises 17 and 65 percent respectively of the heroin seized today in the United States. Both countries have been aggressive in their heroin-control programs. Mexican eradication has destroyed between 60 and 70 percent of the crop each year for the past several years. In 1999, the government of Mexico removed from production 7,900 hectares of poppies and interdicted 2.13 metric tons of the remaining opium. Aerial spraying in Colombia – some 8,000 hectares of poppies were fumigated in 1999 – has been used to combat the heroin threat. Despite spray operations, in 1999, Colombia's illicit poppy crop increased some 1,400 hectares to 7,500 hectares.[59] This amount of cultivation could potentially produce nearly eight metric tons of heroin. Although Colombia accounts for only 2 percent of worldwide production, almost all of that is destined for U.S. markets.

Total illicit opium production in Asia continued to decline over the last three years, with a net drop of 11 percent in 1999 – primarily due to a drought in Southeast Asia. A dramatic increase in opium production in Afghanistan kept this decline from being even greater. Afghanistan production increased 24 percent in the past year. The government of Pakistan, after years of work and with the assistance of funding from U.S. crop-control programs, has essentially eradicated poppy cultivation in areas were alternative development has been established. Thailand's crop substitution program remains the world's most effective and has contributed to a 91 percent drop in net production since 1985. Eradication programs through the UNDCP resulted in decreases in Southeast Asia, particularly in Laos and to a lesser extent in Burma, but an important factor in this decline was adverse weather, which caused a 38 percent reduction in potential opium production.

Worldwide Heroin Flows



Source: DEA Crime and Narcotics Center

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In the coming decade, additional progress is achievable if governments can cordon off growing areas, increase their commitment, and implement counternarcotics programs. U.S.-backed crop-control programs reduced illicit opium cultivation in countries like Guatemala, Mexico, Pakistan, Thailand, and Turkey. However, progress is unlikely in Afghanistan where the ruling Taliban does not appear committed to narcotics control. The United States will continue supporting UN drug-control programs in Burma and other countries, pressing the Burmese government to take effective anti-drug action. In Colombia, the U.S. will provide additional support to the CNP opium poppy eradication campaign. Twelve twin-engine helicopters (six Bell 212s and six UH-60s) have been given to the CNP to facilitate high-altitude operations. We will help strengthen law enforcement in heroin source countries by supporting training programs, information sharing, extradition of fugitives, and anti-money laundering measures. Finally, the United States will work through diplomatic and public channels to increase the level of international cooperation and support the ambitious UNDCP initiative to eradicate illicit opium poppy cultivation in ten years.

Domestic heroin demand-reduction programs are all the more essential due to difficulties in attacking heroin sources of supply. U.S. law-enforcement agencies use strategic information about domestic heroin distribution rings to break up international crime rings. The ad-hoc task force established in Plano, Texas is an excellent example of this approach. It consists of representatives from numerous area sheriffs' offices and police departments as well as the Texas Department of Public Safety, the U.S. Attorneys' Offices, the U.S. Immigration and Naturalization Service, the FBI, and DEA.

Countering the Spread of Methamphetamine

Since the mid-1980s, the world has faced a wave of synthetic stimulant abuse. Approximately nine times the quantity of such drugs were seized in 1993 compared to 1978, the equivalent of a 16 percent average annual increase.[60] The principal synthetic drugs produced clandestinely are amphetamine-type stimulants. Domestic manufacture and importation of methamphetamine poses a continuing public-health threat. In the past, outlaw motorcycle gangs largely supplied methamphetamine. More recently, Mexican-based trafficking groups dominated wholesale trade in the United States. These organized crime groups have developed large-scale laboratories – both in Mexico and the United States – capable of producing enormous quantities of methamphetamine. The manufacturing process involves toxic and flammable chemicals. Abandoned labs require expensive, dangerous clean-up.

The 1996 National Methamphetamine Strategy (updated in May of 1997) remains the basis for the federal response to this problem. It was buttressed by the Comprehensive Methamphetamine Control Act of 1996, which increased penalties for production and trafficking while expanding control over precursor chemicals like ephedrine, pseudoephedrine, and phenylpropanolamine. It also created a Methamphetamine Interagency Task Force, co-chaired by the Attorney General and the Director of ONDCP. The Methamphetamine Trafficking Penalty Enhancement Act of 1998 was signed into law as part of the omnibus spending agreement for FY 1999, further stiffening sanctions against this dangerous drug. Federal, state, and local investigators are targeting companies that supply precursor chemicals to methamphetamine producers. The DEA also supports law-enforcement agencies by conducting training in Kansas City and San Diego. Many retailers are adopting tighter controls for over-the-counter drugs containing ingredients that can be made into methamphetamine. Useful actions include educating employees, limiting shelf space for these products, and capping sales.

Internationally, the United States is promoting controls over precursor chemicals. Cooperation with Mexico, which is home to powerful methamphetamine trafficking organizations, is crucial. A bilateral chemical-control working group enhances the sharing of information and facilitates mutual assistance on investigations and regulatory matters of interest to both countries. Mexico recently came into compliance with the 1988 U.N. Convention against Traffic in Narcotic Drugs and Psychotropic Substances.

Reducing Domestic Marijuana Cultivation

Marijuana is the most readily available illegal drug in the United States. While no comprehensive survey of domestic cannabis cultivation has been conducted, the DEA estimates that much of the marijuana consumed in the United States is grown domestically, both outdoors and indoors, by commercial and private operators. The DEA-coordinated Domestic Cannabis Eradication and Suppression Program provides support to state and local law-enforcement agencies. In FY 1998, this program contributed to the seizure of more than 2.5 million marijuana plants. The Department

of the Interior is deeply co[illegible]ned about marijuana cultivation on public and tribal lands. Suppression of marijuana cultivation (and clandestine drug laboratories) on approximately 525 million acres for which the Interior Department has stewardship is a priority for its four bureaus with major law-enforcement responsibilities.

Recognizing that successful domestic cannabis eradication must be supported by information about the acreage of illegal drug cultivation, Congress, in ONDCP's 1998 reauthorization, directed the Secretary of Agriculture to submit to the ONDCP director an annual assessment of illegal drug cultivation in the United States.[61] The detection of cannabis from aerial platforms remains a problem due to difficulty in developing spectral signatures unique to cannabis. This problem is primarily due to the high degree of genetic heterogeneity of illicit cannabis as well as the general practice of concealing small plots within agricultural plantings, e.g. corn, or on public lands. Because the plots of land are often small, satellite imagery is not a viable option. Despite these difficulties, the Agricultural Research Service, in cooperation with NASA and the Naval Systems Weapons Laboratory, made progress in developing hand-held sensors for deployment in helicopters.

Mycoherbicides

Mycoherbicides utilize naturally occurring microbial enemies of the coca, opium poppy, and marijuana plant that cause the crop to wilt. ONDCP stated in its March 1, 1999 report to Congress that mycoherbicides could become a critical tool in controlling coca and poppy production abroad and marijuana cultivation within the United States. ONDCP transferred $4.5 million in fiscal year 1999 to the United States Department of Agriculture's (USDA) Agriculture Research Service to support studies dealing with biocontrol alternatives to herbicidal eradication. These funds, along with nearly $23 million Congress provided through the State Department's Bureau of International Narcotics Control and Law Enforcement for use on bio-control of narcotics crops in fiscal year 1999, represent a significant investment in the future of illicit crop eradication. The grant also provided for the detection and estimation of illicit narcotics crops and the development of economic alternatives to drug cultivation in foreign countries. In the coming year, the United States and the United Nations are working together to begin small-scale field testing of mycoherbicides.

INTERNATIONAL DRUG-CONTROL COOPERATION

The transnational nature of the drug threat prevents any country from successfully combating it unilaterally. Our efforts to reduce drug availability, abuse, and adverse consequences within the United States are supported by extensive international activities. International programs confront illegal drug cultivation, production, trafficking, abuse, diversion of precursor chemicals, and the corrosive effects of the illegal drug trade – including corruption, violence, environmental degradation, damage to democratic institutions, and economic distortion.

A series of bilateral, multilateral, sub-regional, regional, and global accords create a bulwark for anti-drug measures. The international community's mature understanding of the scope of this problem is helping dissolve the myth that the U.S. market is the engine driving the global drug trade. In fact, the United States comprises just 2 percent of the world's consumers. Even with the relatively high price Americans are willing to pay for illegal drugs, U.S. citizens still account for only 10 to 15 percent of more than four hundred billion dollars spent globally on drugs every year.[62]

Drug Control Efforts through International Organizations

Over the past year, the United States has been extremely successful in working with a number of international organizations on supply reduction. Following the June 1998 United Nations General Assembly Special Session, the United States increased its drug control efforts through international organizations.

Recent U.S. activities through the UN Drug Control Program resulted in an expansion of South East Asia programs that focus on Burma, improved alternative development in Pakistan, and training law-enforcement officials in Asia and Latin America. In addition, UNDCP established regional Caribbean efforts to teach judicial personnel how to handle narcotics-related cases, assisted Southern African nations in developing anti-drug legislation, and established demand-reduction centers in Central Europe.

The contributions of the U.S. to the Colombo Plan's Drug Advisory Program led to increased commitment from other donors, particularly Japan, Korea, and Australia.

Contributions fostered the development of host nation-funded drug treatment and drug- prevention coalitions in a number of countries throughout South and Southeast Asia.

The Department of State assisted in strengthening the mechanisms of the Dublin Group to enable it to be more effective in coordinating donor counternarcotics assistance. The Dublin Group is an informal donor coordination effort organized by the U.S., Australia, Japan, Norway, and the EU. The Department of State has also been successful in eliciting greater participation by European countries in international drug programs such as the effort to assess Nigeria's needs for assistance in the field of drug control.

Through the dynamism of the Inter-American Drug Abuse Control Commission (OAS/CICAD), a strong hemispheric consensus has developed and resulted in a regional anti-drug strategy. With Department of State funding, OAS/CICAD has launched training and technical assistance programs in all major narcotics control areas — from developing crop surveys to developing legal systems and strengthening national drug control agencies.

Certification for Major Illicit Drug-Producing and Transit Countries

The legislatively mandated certification process is an important instrument in our international narcotics control policy. Under this law, the President is required to identify major illicit drug producing and transit countries on an annual basis and then "certify" whether these nations cooperated fully with the United States or took adequate steps on their own to implement the 1988 UN Drug Convention. The President must impose certain economic sanctions on countries that do not meet these requirements unless he certifies that vital interests of the United States preclude such sanctions. The sanctions include cutting off foreign assistance (other than humanitarian and counternarcotics aid) and voting against requests for loans from multilateral lending institutions. The certification process helps underscore the importance the United States attaches to international narcotics control and encourages some countries to take steps they might otherwise have avoided in pursuit of sound drug control policy. At the same time, this unilateral certification process is contentious in many countries.

Promoting International Demand Reduction

The problem of increasing drug abuse is shared by many nations. In 1996, the latest year for which a geographically balanced database exists, cannabis consumption increased in thirty-one nations, amphetamine type stimulant use increased in twenty-six, heroin use increased in twenty-one, cocaine consumption rose in eighteen, hallucinogen use increased in twelve, inhalant use rose in twelve, and benzodiazapine use increased in nine.[63] Drug-use rates also increased in "source" and "transit" countries. In Colombia, the most recent official national survey showed lifetime drug-use rates increased from 0.6 percent of the population in 1992 to 6.5 percent in 1996.[64] In Mexico, lifetime use of illegal drugs increased from 3.9 percent of the population in 1993 to 5.3 percent in 1998 — a 36 percent increase.[65]

Recognizing that no government can reduce drug use and its consequences by itself, the United States works closely with individual countries and regional organizations on demand-reduction initiatives. The United States and Mexico hold annual binational demand reduction conferences; the third will be held in Phoenix, Arizona in May/June 2000. The U.S. participated in a demand reduction symposium in Bridgetown, Barbados, in March 1999. In October 1999 a Central American demand reduction summit was held in Guatemala. At this regional summit, eight countries from the Central America addressed the importance of epidemiological data collection and research for understanding the drug issue locally and to identify and prioritize their next steps. Federal public-health agencies are collaborating with the European Monitoring Centre for Drugs and Drug Addiction in Lisbon, Portugal to improve national survey instruments.

The U.S. Government also encourages private-sector initiatives in drug prevention education. Examples include the *Consejo Publicitario Argentino*, the *Parceria Contra Drogas* in Brazil, and the *Alianza para una Venezuela sin drogas*. Approximately 120,000 U.S. tax dollars helped establish these national organizations and contributed to the generation of more than 120 million dollars in anti-drug media messages in these three countries. The U.S. helped launch similar organizations in Peru and Uruguay in 1999. The Department of State supports public diplomacy campaigns that publicize the threat drugs pose to societies in source and transit nations.

Supporting Democracy and Human Rights

Democracies make peaceful neighbors and reliable trade partners. They are good for security and provide an environment for cooperation on drug issues. Democracies have a greater propensity to respect human rights, are less tolerant of corruption, and are more likely to build legal systems that set fair ground rules for everybody – including foreign investors. If any areas in the world can boast of a sweeping trend toward greater respect for democratic practices in the past quarter-century, Latin America and the Caribbean can be proud of their efforts. Civil society is still very weak in some countries. Greater honesty and ethics in government, improved administration of justice, effective and humane law enforcement, and greater respect for free expression are all needed.

The Administration continues to be very sensitive about human rights. Under the Leahy Amendment to the FY 1999 Foreign Operations Appropriation Bill, the administration can only provide training and assistance to those security units that do not tolerate violations of human rights. If the Secretary of State has credible evidence that a unit committed gross violations of human rights, no funds made available by that Act may be provided unless the Secretary reports to the Committees on Appropriations that the foreign government responsible is taking steps to bring the culprits to justice.

Regional Drug Control in the Western Hemisphere and the Multilateral Evaluation Mechanism

The Organization of American States' Inter-American Drug Abuse Control Commission (OAS/CICAD) has become an essential link in our international drug-control regime. U.S. contributions to OAS/CICAD have had a direct impact on the development of model workshops to target money laundering and asset forfeiture, regional mechanisms for tracking pre-cursor chemicals, anti-drug laws, and judicial or legal training.

After eighteen months of discussion and negotiation, a Multilateral Evaluation Mechanism (MEM) was inaugurated in 1999 during the twenty-sixth regular session of CICAD in Montevideo, Uruguay (October 1999). The MEM is a multilateral system of counter-drug performance measurement. Its creation was mandated by thirty-four heads of state who attended 1998 Summit of the Americas in Santiago, Chile. The establishment of the MEM will have no direct impact on the United States' annual drug certification process, which is required by law. The MEM will help to address this issue.

Although individual nations have made progress in developing comprehensive counterdrug strategies, many have yet to develop an adequate system to collect and report basic statistics on drug use, production, seizures, arrests, money laundering, chemical diversion, and drug trafficking. In addition, the data many nations collect is based on different methodologies. This problem prevents accurate regional comparisons, discourages information sharing, and inhibits the development of a hemispheric picture of the drug problem as it changes over time. MEM was designed to fix these difficulties.

Initial steps for implementing the MEM have already been taken. Nations have been sent a detailed questionnaire with sixty-two performance indicators, which require detailed answers pertaining to prevention, treatment, law enforcement, and interdiction. The questionnaires will be turned over for review to a Government Experts Group (GEG). Recommendations will be written by the GEG and published by CICAD on the Internet. Results of the first round of evaluations will be reported to the hemisphere's presidents at the Summit of the Americas in 2001 in Quebec City, Canada.

Bilateral Cooperation with Mexico

Most of the cocaine and much of the marijuana, heroin, and methamphetamine consumed in the U.S. comes through Mexico. Mexican drug networks control a substantial portion of the illicit drugs distributed in the United States. Conversely, cash and firearms derived from illegal drug trafficking move South from the U.S. into Mexico.

Senior levels of the Mexican government are willing to confront the national security threat posed by drug trafficking, drug-related corruption, and violence. Corruption and fragile counter-drug institutions have hurt Mexico. Mexico must remain committed to disrupting drug-trafficking organizations and reducing the amount of illegal substances that enter Mexico and the United States.

In the last four years, Mexico prosecuted a number of high-ranking public officials for corruption. It

established a Confidence Control Center to address corruption. Mexico enacted anti-crime laws that strengthen law enforcement and provide the basis for effective prosecution. Cooperation between the two nations improved in terms of counterdrug information sharing, investigations, extradition, and military coordination. Twenty-five metric tons of cocaine were seized as the result of maritime coordination between the U.S. Coast Guard and the Mexican Navy during the first nine months of 1999. In January 2000, the U.S. and Mexico will conduct the first opium yield survey in almost fifteen years.

In 1998, the United States and Mexico developed a comprehensive bi-national anti-drug strategy. The strategy builds on the *Bi-national Drug Threat Assessment and the U.S.-Mexico Alliance against Drugs* signed by Presidents Clinton and Zedillo in 1997. The agreement demonstrates the shared commitment to address drug problems while upholding the principles of sovereignty, mutual respect, territorial integrity, and nonintervention. The U.S./Mexico Performance Measures of Effectiveness, developed in February 1999, are designed to measure progress by Mexico and the U.S. in implementing the bi-national strategy. A second bi-national demand-reduction conference was held in Tijuana, Mexico in June of 1999, and a third conference will take place in Phoenix, Arizona in May/June of 2000.

Over the long term, the United States and Mexico need to preserve institutions of cooperation like the U.S.-Mexico High Level Contact Group (HLCG) for Drug Control and the Senior Law Enforcement Plenary. Mexico must strengthen its law-enforcement and anti-corruption efforts in order to reduce the flow of drugs. Our two nations must also ensure the safety of law enforcement personnel who are confronting violent criminal drug organizations.

Targeting International Drug Trafficking Organizations

Over the last decade, Latin American drug-trafficking organizations fundamentally changed the way they do business. A diverse group of smaller, specialized Colombian drug rings have emerged following the collapse of the Medellin and Cali cartels. The smaller suppliers in South America and the transportation groups in the Caribbean and Mexico filled the void left by the demise of the large cartels and expanded their roles in the international cocaine industry.

The increase in smaller suppliers, producers, and trafficking groups made targeting drug-trafficking organizations much more difficult. The sheer power, influence, and sophistication of these groups put them in a category by themselves. Whereas traditional Mafia families bribed officers and judges, today's international drug organizations corrupt entire institutions of government.

These traffickers model their operations after international terrorists. They maintain tight control of their workers through highly compartmentalized cell structures that separate production, shipment, distribution, money laundering, communications, security, and recruitment. Traffickers have at their disposal the most technologically advanced airplanes, boats, vehicles, radar, communications equipment, and weapons. They have also established vast counterintelligence capabilities and transportation networks.

Although presented with a problem of growing complexity, international law enforcement had a number of important successes in 1999. One was *Operation Millennium*, a Special Operations Division investigation discussed previously. *Operation Impunity* was a year-long OCDETF and HIDTA investigation designed to dismantle a narcotics importation/distribution network that smuggled tonnage quantities of cocaine across the Southwest border at McAllen, Texas. The network concealed cocaine in tractor-trailers carrying watermelons and other produce. After the cocaine was smuggled across the border, the cocaine would be trucked to distribution centers in the Northeast and in the Chicago area. Members of the organization also collected millions of dollars in drug proceeds and transported the currency to Mexico in bulk shipments. *Operation Impunity* resulted in seizures netting 12,357 kilograms of cocaine, one-half kilo of heroin, 4,806 pounds of marijuana, and more than $19 million in U.S. currency. Prosecutors charged a total of 105 defendants in this operation.

International Money Laundering Efforts

A multi-agency training program is helping banks and law-enforcement agencies in emerging democracies detect and deter money laundering. Treasury's Financial Crimes Enforcement Network (FinCEN) and the Internal Revenue Service Criminal Investigation Division continue to work closely with other components of the US government and international partners to foster multilateral and bilateral initiatives to increase the number of countries

engaged in the fight against money laundering. The efforts to build effective international cooperation encompass two major areas of activity: (1) establishing or strengthening its financial intelligence unit counterparts, and (2) facilitating the exchange of information among these institutions in support of anti-money laundering investigations.

The United States supports global efforts to disrupt the flow of illicit capital, track criminal sources of funds, forfeit ill-gained assets, and prosecute offenders. Twenty-nine nations belong to the Financial Action Task Force (FATF): Argentina, Brazil, and Mexico participate as observers. Formed by the G-7 Economic Summit in 1989, the FATF is dedicated to promoting anti-money laundering controls around the world. As a result, all members of the FATF have now criminalized money laundering and are working toward implementing a full range of international anti-money-laundering standards.

Working with the FATF and other governments, the U.S. promotes the establishment of FATF-style regional bodies. A major achievement of the FATF in 1999 was the second mutual evaluation of each member's anti-money laundering measures. The FATF's system of mutual evaluations has proven successful in ensuring that the standards are implemented consistently by each of the member governments and in spurring governments to make improvements in their individual systems. This past year, progress was made in creating an internationally accepted methodology to measure the financial dimensions of the illicit drug industry. In 1999, a unique partnership was forged among the G-7 FATF, the United Nations Drug Control Program, European Drugs Monitoring Center, and several other European agencies to produce the first reliable estimate of illicit drug proceeds in the FATF nations.

In addition, the United States has been working with FATF to develop Financial Intelligence Units (FIUs), which receive, analyze, and (where appropriate) refer for prosecution suspicious transactions reported by financial institutions. The operation of financial intelligence units (FIUs), modeled after FinCEN, may prove to be one of the most effective means for combating money laundering around the globe. This development provides a centralized mechanism for tracking criminal proceeds, collecting investigative data, and contributing to international cooperation by combating money laundering. There are now forty-eight FIUs in operation with more in the planning stages. The United States has been assisting interested countries with technical support associated with FIU operation. Currently, FinCEN is working with governments to share information through a secure Intranet. Accomplishing this goal will be important to U.S. efforts to identify, investigate, and prosecute transnational financial crimes.

The United States government is also attacking the financial networks of drug trafficking organizations by seizing illegally gained assets. In December of 1999, the President signed into law the Foreign Narcotic Kingpin Designation Act, which establishes a global program targeting the activities of narcotics traffickers. The new act provides a statutory framework for the President to institute sanctions against foreign drug kingpins in order to deny illegal businesses access to the U.S. financial system and benefits from U.S. trade. Once locked out of American trade, criminal organizations have difficulty participating in open commerce.

One facet of international money laundering — the Black Market Peso Exchange (BMPE) system — is of particular concern to the United States. The BMPE is the primary money laundering conduit used by Colombian narcotics traffickers in repatriating drug revenues from the United States. In this scheme, Colombian cartels sell U.S. currency earned from the sale of illegal drugs to black market peso brokers in Colombia. These brokers, along with their U.S.-based agents, place the dollars back into U.S. bank accounts while circumventing the Bank Secrecy Act reporting requirements. The exchange agents re-sell monetary instruments drawn on their bank accounts in the U.S. to Colombian importers who use these instruments to purchase foreign goods. Anecdotal law enforcement evidence, informant statements, and Colombian government officials estimate BMPE trade at between $3 billion and $6 billion a year.

Actions directed against drug assets work best when undertaken with international support. The United States must continue encouraging other nations to join in coordinated efforts against drug organizations. As kingpin designations are made under the new law, we will continue working with host governments to pursue additional measures against drug criminals.

International Asset Forfeiture Cooperation

In this era of globalization, the Department of Justice's efforts to disrupt and dismantle drug trafficking organizations mandate international cooperation at all levels. In addition to working with other countries to develop international forfeiture cases, DOJ actively promotes international cooperation to halt the flow of illegal proceeds across borders and into foreign financial institutions through the negotiation of bilateral forfeiture cooperation and asset sharing agreements. Since the beginning of the program, DOJ has obtained some $192 million in forfeitures with the assistance of twenty-three countries and some $66 million has been shared with those cooperating countries. In FY 1998, the department continued its cooperative efforts with a variety of foreign countries. For example, the United States worked with Switzerland to complete the forfeiture of $178 million in assets held in Switzerland in connection with the 1995 prosecution of Sheila Arana de Nasser, ex-wife of notorious Colombian drug-trafficker Julio Nasser David. Approximately fifty percent or $89 million was repatriated in December 1998 to the United States as the result of an agreement with Switzerland.

Controlling Precursor Chemicals

The twenty-two chemicals most commonly used in the production of cocaine also have extensive industrial applications. We can disrupt illegal drug production if these chemicals are difficult to obtain. For this reason, an important element in the U.S. drug-control policy is to insure that all countries have flexible system that regulates the flow of precursor chemicals without jeopardizing legitimate commerce. The Multilateral Chemical Reporting Initiative – formulated by the U.S. and accepted internationally – completed its second year in 1999. This program encourages governments to exchange chemical-control information on a voluntary basis in order to identify suspicious orders. Over the past decade, key international bodies like the Commission on Narcotic Drugs and the U.N. General Assembly's Special Session (UNGASS) have addressed the issue of chemical diversion in conjunction with U.S. efforts. These organizations raised specific concerns about potassium permanganate (a chemical essential in making cocaine) and acetic anhydride (a heroin precursor).[66]

To facilitate the flow of information about precursor chemicals, the United States – through its relationship with the Inter-American Drug Control Abuse Commission (CICAD) – continues to assess the status of precursor chemicals and assist countries in strengthening controls. Many countries still lack the capacity to determine whether the import or export of precursor chemicals is related to legitimate needs or illicit drugs. The problem is complicated by the fact that many chemical shipments are directed through third countries in an attempt to disguise their purpose and destination. More can be done to prevent diversions, and the international community – through the United Nations – has become increasingly involved in concerted global action to limit the availability of precursor chemicals.

In countries where strict chemical controls were put in place, illicit drug production has been seriously affected. For example, few of the chemicals needed to process coca leaf into cocaine HCl are manufactured in Bolivia. Most are smuggled in from neighboring countries with advanced chemical industries. DEA estimates that licensed importers are diverting only small amounts. However, increased interdiction of chemicals, particularly in the Chapare, raised the price of many smuggled chemicals in 1998. Bolivian lab operators are now using inferior substitutes (cement instead of lime, sodium bicarbonate for ammonia), recycled solvents (ether), and a streamlined production process that virtually eliminates oxidation in producing cocaine base. Some laboratory operators are not using sulfuric acid during the maceration stage; consequently, less cocaine alkaloid is extracted from the leaf, producing less HCl. The lower quality of Bolivian cocaine has affected its marketability.

In 1999, *Operation Purple* was conducted with the cooperation of seven major countries that produce potassium permanganate, exporting/transshipment countries, and cocaine producing countries of the Andean region. This operation tracked shipments of potassium permanganate that were greater than a hundred kilograms. During seven months of operation, these investigative efforts had a major impact on the traffickers' ability to obtain chemicals necessary to process cocaine. There were twenty-four shipments seized or halted during transit – accounting for 1.7 million kilograms of potassium permanganate – which, if used for processing cocaine, could have created up to seventeen million kilograms of the drug.

Reducing Corruption

Like an opportunistic disease attacking a weakened immune system, the drug trade draws strength from the economic, social, and moral decay that corruption fosters. Drug syndicates exacerbate corruption through wealth. Enormous resources give the large drug organizations a nearly open-ended capacity to corrupt. We have seen instances in the recent past where senior officials charged with destroying drug syndicates were in fact in the syndicates' employ. By focusing world attention on the need to eliminate corruption, we can prevent this fate from befalling elected governments.

Stemming corruption and protecting the integrity of a nation's judicial system were central to Vice President Gore's global forum on fighting this problem, held in February 1999. Corruption was also discussed at the Western Hemisphere Drug Policy summit held in November 1999. Both forums emphasized the need for justice, security, and financial regulatory officials as well as accountability in the private sector and the press. Nations suffering from corruption must take the tough measures required to develop democratic institutions that inspire investor confidence and public support.

Endnotes

1 Yoshikawa, H., "Long-Tem Effects of Early Childhood Programs on Social Outcomes and Delinquency," *Future of Children*, 1995, 5 (3): 51-75.

2 Professor Jay Winsten from Harvard's School of Public Health used television to introduce the concept of a "designated driver," not via the typical public service announcement, but instead by incorporating scenes and dialogue that conveyed a message about not driving while drunk. With assistance from then NBC Chairman Grant Tinker, Winsten met with more than 250 writers, producers, and directors. As a result, the "designated driver" message aired on 160 prime-time shows. A year after the "designated driver" concept was invented, a Gallup Poll found that 67 percent of adults had noted its appearance on network television.

3 On-line resources include: www.whitehousedrugpolicy.org/; www.samhsa.gov/csap/; www.ojjdp.ncjrs.org/; www.health.org/.

4 U.S. Department of Health and Human Services, *Prevention Works Through Community Partnerships: Findings from SAMHSA/CSAP's National Evaluation*, DHHS Publication No. (SMA)00-3373, Printed 2000, p. 5, Monograph. The study found that adults reporting less illicit drug use also referred to four conditions, correlated with lower rates of substance use. These include 1) living in an anti-drug partnership community, 2) being involved in substance abuse prevention activities, 3) living in a neighborhood perceived to have minimal illicit drug trading or illicit drug markets, and 4) having a disapproving attitude toward the use of illicit drugs.

5 Information about the "Prevention Through Service" Alliance can be obtained at http://www.ptsa.net/, January 29, 1999.

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20 This web site provides outreach to small businesses, a Substance Abuse Information Database, and the interactive Drug-Free Workplace Advisor. To date, *Working Partners* has armed two-thousand business associations and labor organizations with information and other resources to implement effective drug-free workplace programs, and has answered more than twenty-one thousand customer inquiries about the Drug-Free Workplace Act of 1988 and similar issues.

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50 MSBs include businesses and their authorized agents who provide the distinct but often-complementary services of money transmission, check cashing, currency exchange, and the issuance, sale and redemption of money orders and traveler's checks.

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59 Crime and Narcotics Center (CNC) briefing, February 2000. Colombian cultivation estimates assumes that three crops per year will be planted by the regions' farmers; therefore, a relatively small amount of land detected — 2,500 — results in a larger year-end cultivation estimate.

60 The Methamphetamine Interagency Task Force brought together federal and non-federal experts who reviewed current practices regarding methamphetamine. The Task Force published a report that describes the methamphetamine problem and makes recommendations in the areas of law enforcement, prevention and education, and treatment. The report also establishes research priorities to advance the understanding of the nature and effects of the methamphetamine problem and to measure the effectiveness of prevention, enforcement, and treatment interventions. A final section discusses promising strategies that the federal government should undertake to assist communities in combating methamphetamine. The Task Force Co-Chairs announced in January that demonstration programs will be developed in several cities, using the local U.S. Attorney's office to facilitate local prevention, treatment and law enforcement strategies to combat the spread of methamphetamine.

61 Section 705(a)(2)(B)(3) of the ONDCP Reauthorization Act of 1998.

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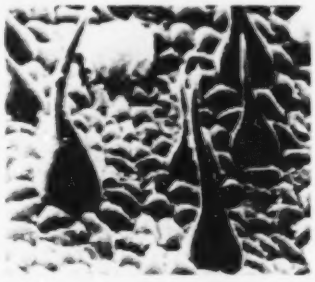
HONESTY.

THE ANTI-DRUG.

Your kids ask if you ever used drugs. What do you say? You want to be honest because you love them and respect their intelligence. It's a very difficult question. But remember, **the issue isn't your past. The issue is their present and future.** How you respond is entirely up to you. (Perhaps tell them when they're older.) What's important now is that your kids understand that you don't want them to use drugs. Studies show that parents who give their kids **clear rules and reward them for good behavior** are far more effective in keeping their kids off drugs than those who don't. For more information, visit www.theantidrug.com or call 800.788.2800. We can help you.



This is where THC comes from. THC is the active ingredient in marijuana. It looks the same today as it did in 1960. The difference is how much of it is in marijuana today. Pot today is often grown hydroponically and can be genetically altered to produce more THC in each plant. The production of marijuana is a commercial industry that in many ways has created a drug much different than it was in the 70's.

Smoking marijuana is harmful. The younger you are, the more harmful it is. Research has shown that people who smoke marijuana before the age of 15 are 7 times more likely to use other drugs than people who don't smoke marijuana. Studies also show that people who did not smoke marijuana by the time they were 21 were more likely to never smoke marijuana. This message is brought to you by the Office of National Drug Control Policy/Partnership for a Drug-Free America®

IV. The National Drug Control Budget

The FY 2001 National Drug Control Budget supports the five goals and thirty-one objectives of the *National Drug Control Strategy* and is structured to make progress toward the targets outlined in the *Performance Measures of Effectiveness* (PME) system. In total, funding recommended for FY 2001 is $19.2 billion, an increase of $760 million over the FY 2000 level of $18.5 billion, which includes proposed supplemental funding of $954 million to support *Plan Colombia* and drug control activities in the Andean region. A summary of drug-control spending for FY 1998 through FY 2001 is presented in Figure 4-1.

Funding by department for FY 1999 to FY 2001 is displayed in Table 4-1. Additional resources for supply-reduction programs in the Departments of Justice, Treasury, Transportation, State, and Defense will aid efforts in Colombia and the Andean region, support security along the Southwest border, and continue enforcement operations targeting domestic sources of illegal drugs. Demand-reduction efforts by the Departments of Health and Human Services and Education will support programs to increase public drug treatment, provide basic research on drug use, and continue prevention efforts aimed at school children.

Support for *Plan Colombia* & the Andean Region

The President's budget proposes $1.6 billion in FY 2000 and FY 2001 funding for counternarcotics efforts in the Andean Region, primarily in Colombia. This builds on current funding for Colombia of over $330

Figure 4-1: National Drug Control Budget

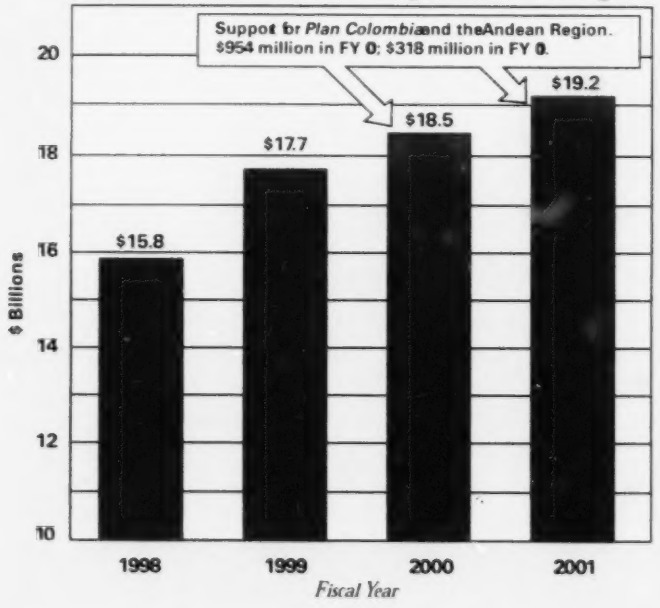


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Table 4-1: Drug Spending by Department ($ Millions)

Department	FY 99 Actual	FY 00 Estimate	FY 01 Request	FY 00-01 Change	% Change
Defense	974.9	1,005.2	1,029.1	23.8	2.4%
Education	663.2	698.1	750.9	52.8	7.6%
HHS	2,866.1	3,078.9	3,264.8	185.9	6.0%
HUD	310.0	310.0	315.0	5.0	1.6%
Justice	7,398.5	7,443.2	8,236.9	793.7	10.7%
ONDCP	453.2	461.4	496.8	35.4	7.7%
State	498.7	282.8	276.8	(6.0)	(2.1%)
Transportation	871.1	631.0	684.9	53.8	8.5%
Treasury	1,756.5	1,499.6	1,688.3	188.7	12.6%
Veterans Affairs	1,041.7	1,111.4	1,155.5	44.1	4.0%
All Other	877.3	978.8	997.5	18.7	1.9%
Subtotal	17,711.2	17,500.6	18,896.4	1,395.9	8.0%
Plan Colombia & Andean Region		954.4	318.1		
Total	17,711.2	18,455.0	19,214.5	759.6	4.1%

million and includes $1.3 billion in new funding. An estimated 80 percent of the cocaine that enters the United States originates in or passes through Colombia. Up to eight metric tons of heroin is produced annually in Colombia, and much of this total is shipped to the United States. Cultivation of coca, the raw material for cocaine, has nearly tripled in Colombia since 1992. In addition, Colombian traffickers and coca farmers have recently adopted new cultivation and processing techniques, increasing the amount of drugs processed from each acre of crop. Colombia now cultivates more than half of the coca leaf grown in the world. If unchecked, the rapid expansion of coca crops and cocaine production in Colombia threatens to increase significantly the global supply of cocaine over the next several years.

Efforts by the government of Colombia to attack the drug trade are hampered by the fact that guerrillas and paramilitary groups control Colombia's major drug-producing regions. In addition to these armed groups, organized drug mafias continue to run international aspects of Colombia's drug trade. The money produced by the drug trade enriches these outlaw groups, which generate violence and corruption while threatening Colombia's democratic institutions. These problems contribute to the country's insecurity, which is compounded by the worst economic recession Colombia has experienced in almost seventy years.

The democratically elected government of Colombian President Andres Pastrana devised a comprehensive, integrated strategy, called *Plan Colombia*, to address Colombia's drug and interrelated social and economic troubles. The Administration proposes $1.6 billion for assistance, including an increase of $1.3 billion in support of *Plan Colombia* – consisting of a FY 2000 supplemental appropriation of $954 million and new FY 2001 funding of $318 million.

No single solution can cure all of Colombia's difficulties. Consequently, the program is an integrated combination of funds for Colombian counterdrug efforts and for other programs to help President Pastrana strengthen democracy and promote prosperity. The proposal would enhance alternative development; strengthen the justice system and other democratic institutions; and provide counterdrug equipment, training, and technical assistance to Colombian police and military forces. The U.S. government is encouraging our allies, along with various international institutions, to assist Colombia in implementing President Pastrana's plan. The budget proposal provides additional funding for counterdrug regional interdiction and alternative development to shore up significant gains against drug production in Peru and Bolivia and prevents traffickers from simply moving their operations to avoid law enforcement.

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Major Increases in FY 2001

The following major increases in drug control funding are included in the President's FY 2001 budget for **prevention and treatment** programs:

- **Stop Drugs – Stop Crime: +$112 million.** In order to break the cycle of drug use and its consequences, drug-abusing inmates in local, state and federal correctional systems need access to drug treatment and supervision. The President's FY 2001 budget includes several enhancements in support of this effort:
  - **OJP & ONDCP Support: +$100 million.** New funding is requested to help states and localities implement new systems of drug testing, treatment, and graduated sanctions for persons under supervision of the criminal justice system — including prisoners, parolees and probationers. This funding consists of $75 million provided through the Office of Justice Programs (OJP) and $25 million from ONDCP's Special Forfeiture Fund. OJP's support includes $25 million targeted to offenders who are re-entering society.
  - **Drug Courts: +$10 million.** These additional resources will bring total funding for the Drug Courts program to $50 million in FY 2001. This initiative provides alternatives to incarceration through using the coercive power of the court to force abstinence and alter behavior with a combination of escalating sanctions, mandatory drug testing, treatment, and strong after-care programs.
  - **Residential Substance Abuse Treatment (RSAT) Program: +$2 million.** This funding will continue expansion of the RSAT program. RSAT is a formula grant program that provides funds to states for state and local correctional agencies to provide intensive drug treatment to hardcore drug users before and after they are released from prison.
- **National Youth Anti-Drug Media Campaign: +$10 million.** These additional resources bring total federal funding for ONDCP's Media Campaign to $195 million for FY 2001. This figure will be matched by private sector contributions. In conjunction with other federal, state, local, and private experts, ONDCP is implementing a $2 billion, multi-year national media campaign, including paid advertisements. The campaign targets youth, their parents, mentors and other influential adults about the consequences of illicit drug use. The anti-drug media campaign uses television, the Internet, radio, newspapers, and other media outlets.
- **Safe and Drug-Free Schools Program: +$50 million.** The President's Budget includes $40 million to expand the interagency Safe Schools/Healthy Students initiative, which supports community-wide prevention activities in conjunction with HHS and the Department of Justice. Also, the budget includes $50 million to continue the School Coordinator Initiative, started in FY 1999. In FY 2001, this effort will support drug and violence prevention coordinators in over 1,300 middle schools across the country to ensure that local programs are effective and link school-based prevention programs to community-based efforts.
- **Targeted Capacity Expansion (TCE) Program: +$53.8 million.** This additional funding will help the Substance Abuse and Mental Health Services Administration (SAMHSA) expand the availability of drug treatment in areas of existing or emerging treatment need. Further, these new resources will enable SAMHSA to provide additional states with State Incentive Grants.
- **Substance Abuse Block Grant Program: +$31.0 million ($22 million drug-related).** This increase for SAMHSA's Substance Abuse Block Grant will provide funding to states for treatment and prevention services. This program is the backbone of federal efforts to reduce the gap between those who are actively seeking substance abuse treatment and the capacity of the public treatment system.
- **Treatment and Prevention Research: +$37.2 million.** The FY 2001 budget includes new funding for research conducted by the National Institutes of Health. Research is essential in educating America's youth to reject drugs and decreasing the health and social cost of drugs to the American public. Funding supports activities of the National Institute on Drug Abuse (NIDA), whose programs include the National Drug Abuse Treatment Clinical Trials Network, prevention research, medications and behavioral therapies, and relapse prevention.
- **Community Anti-Drug Coalitions: +$5 million.** With this enhancement, total funding for this ONDCP grant program will be $35 million in FY 2001. This initiative provides resources to groups to build and sustain effective community coalitions that help prevent drug use by youth. Sustained, comprehensive prevention at the community level is conducted by local leaders dealing with drug prevention, treatment, education, law enforcement, government, faith, and business.

The following major increases in drug control funding are included in the President's FY 2001 budget for **supply reduction** programs:

- **Prison Construction: +$420 million** (drug related). This enhancement is a multi-year project that includes program increases for partial site and planning of two penitentiaries and three medium security facilities in FY 2001. The balance of funds for these five institutions is requested for FY 2002 as advance appropriations. Funding is also requested in FY 2001 to complete the construction of ongoing projects, including one penitentiary and five medium security facilities. Further, advanced appropriations are being requested (FY 2002 $467 million drug related, and FY 2003 $316 million drug related) for a secure female unit, four medium security institutions and one penitentiary. The Bureau of Prisons (BOP) is experiencing dramatic increases in the number of inmates due to more prosecutions, particularly drug cases. This fact, in combination with recent increases in immigration cases, is the primary cause of growth in inmate population.
- **Forward Operating Locations (FOLs) – DoD: $77.9 million.** The drug control budget for the Department of Defense includes these resources in FY 2001 for Military Construction funding for FOLs in Ecuador, Aruba and Curacao. This will reinstate some of the counterdrug support capabilities that had been resident in U.S. military bases in Panama.
- **Customs Enforcement Infrastructure Enhancements: +$112.5 million** (drug related). This funding will continue Customs efforts to shield America's land, air, and sea frontiers from the drug threat and provide new funding to enhance and modernize the Customs Air Program. A portion of these funds will be used to purchase additional flight safety systems, as well as upgrades to radar systems and computer capabilities ($19.8 million drug and non-drug).
- **Coast Guard's Campaign Steel Web Enhancements: +$43.8 million** (drug related). These additional resources will support the United States Coast Guard's drug interdiction efforts, primarily in the transit zone region of the Caribbean and Eastern Pacific. In particular, funding will be used to expand the implementation of the Coast Guard's non-lethal use-of-force initiative that has proven effective at disabling non-commercial maritime craft used to transport illicit narcotics.
- **Southwest Border – INS: +$28.3 million** (drug related). For the INS, a $24.5 million ($163.3 million drug and non-drug) enhancement is requested for the Border Patrol. This enhancement includes funding for an additional 430 Border Patrol agent positions, $3.0 million (drug related) to continue deployment of the Border Patrol's Integrated Surveillance Intelligence System (ISIS) program, and $7.5 million (drug related) for Border Patrol construction projects. In addition, the INS request includes $3.8 million (drug related) for additional Immigration Inspector positions to staff three new ports along the southern border.
- **DEA Law Enforcement Support & Financial Management: +$65 million.** This funding will expand several DEA activities, including infrastructure support for the FIREBIRD system, Southwest border and money laundering operations, intelligence capabilities, and financial management oversight functions. The principal component of this initiative ($56 million) is for FIREBIRD, the primary office automation infrastructure that provides essential computer tools for agents and support staff.

Spending by *Strategy* Goal

Funding by *Strategy* Goal is summarized in Table 4-2. Funding priorities include resources to reduce drug use by young people (Goal 1), make treatment available to chronic users (Goal 3), interdict the flow of drugs at our borders (Goal 4), and target international and domestic sources of illegal drugs and crime associated with criminal enterprises (Goals 2 and 5). In FY 2001, funding of $2.2 billion is requested for Goal 1, a net increase of $68 million over FY 2000, and $3.7 billion for Goal 3, an increase of $202 million (5.7 percent) over FY 2000. Further, multiagency efforts, which target ports-of-entry and the Southwest border, will expand funding for Goal 4 to $2.5 billion in FY 2001, an increase of 11.4 percent. Funding requested for Goal 2 is $8.2 billion in FY 2001, an increase of $665 million, and resources devoted to Goal 5 will reach $2.5 billion in FY 2001. The budget for Goal 5 includes proposed funding of $954 million in FY 2000 and $318 million in FY 2001 to support *Plan Colombia* and drug control activities in the Andean region.

Table 4-2: Drug Funding by Goal ($ Millions)

Goal	FY 99 Actual	FY 00 Estimate	FY 01 Request	FY 00-01 Change	% Change
1. Reduce youth drug use	2,028.8	2,166.4	2,234.8	68.3	3.2%
2. Reduce drug-related crime	7,574.5	7,568.8	8,233.8	665.0	8.8%
3. Reduce consequences	3,300.6	3,539.2	3,741.6	202.4	5.7%
4. Shield air, land, and sea frontiers	2,724.9	2,243.4	2,500.3	256.8	11.4%
5. Reduce sources of supply	2,082.5	1,982.6	2,185.9	203.3	10.3%
Subtotal	17,711.2	17,500.6	18,896.4	1,395.9	8.0%
Plan Colombia & Andean Region (Goal 5)		954.4	318.1		
Total	17,711.2	18,455.0	19,214.5	759.6	4.1%

Federal Funding Priorities: FY 2001 - FY 2005

By law, ONDCP must annually report its program and budget priorities over a five-year planning period. These priorities also are highlighted in ONDCP's consolidated five-year *Drug Control Budget: FY 2001 to FY 2005*. This volume, required by statute, is produced by ONDCP each November. Through FY 2005, funding for the following major program areas will be emphasized through ONDCP's drug-budget authorities:

- Support for *Plan Colombia* and drug control activities in the Andean region
- National Youth Anti-Drug Media Campaign
- Criminal Justice Treatment Programs and closing the public treatment gap
- Drug Courts
- Community Coalitions
- School Drug-Prevention Programs
- High Intensity Drug Trafficking Area (HIDTA) Programs
- Southwest Border Programs
- Intelligence Architecture Support
- Regional Interdiction Architecture: Forward Operating Locations.

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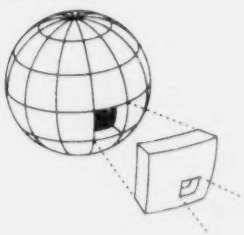
LOVE.

THE ANTI-DRUG.

Spending time with your kids is a proven deterrent to drug use. Listening to them. Talking about their friends, school, activities. **Asking what they think about anything.** Love. Music. Kosovo. Columbine. Dreams they may have. Research shows that knowing your kids, who they hang out with and their parents as well, dramatically reduces the likelihood that they will get into trouble with drugs. Another effective deterrent **is praising and rewarding them for good behavior. Tell your kids you love them.** Go out for pizza instead of watching TV. Get to know the music your kids like and talk to them about it. **Keeping kids drug-free is achieved in a series of small, personal ways.**

For more information, call 800.788.2800 or visit www.theantidrug.com

Round World



We are all individual parts of a greater whole. Parents play a huge role in this interconnected social landscape. Research shows that kids view parents as their most influential role models. A study also shows that 74% of all fourth graders wish their parents would talk to them about drugs. Overwhelmingly, research demonstrates that kids want parents to be parents. And that is the best deterrent in the fight against drugs.

Between 4 and 6 p.m. is when kids are most likely to try drugs. So keep them busy. Encourage them to try out for the basketball team. Or the school play. Or band. What matters is your involvement. Teenagers want to explore their independence, and yet want the stability provided by routines. This message is brought to you by the Office of National Drug Control Policy/Partnership for a Drug-Free America®

V. Consultation

The Office of National Drug Control Policy Reauthorization Act of 1998 requires ONDCP to consult a wide array of experts and officials while developing the *National Drug Control Strategy*. It requires the ONDCP Director to work with the heads of the National Drug Control Program agencies, Congress, state and local officials, private citizens and organizations with expertise in demand reduction, private citizens and organizations with experience in supply reduction; and appropriate representatives of foreign governments. ONDCP fully met this congressional requirement in 1999.

Consultation with Congress

The development, implementation, oversight, and funding of a comprehensive national drug strategy is an objective we undertake in tandem with Congress. In response, the *Strategy* provides detailed long-term plans for addressing domestic and international trends in drug use, production, and trafficking. Only the federal government has the mandate to pursue international supply-reduction targets. Congress has been concerned about accountability in counter-drug efforts and the long-standing absence of serious performance standards for success. The *Strategy* includes specific benchmarks for the base year (1996) and hard data on results in 1997, 1998, and 1999 (where such data is available). Finally, the *Strategy* includes initiatives to reinforce parents and families as they work to keep young people drug-free, expand treatment, counter drug legalization, and target international criminal organizations responsible for much of the world's drug trade.

During 1999, the executive and legislative branches worked to implement the *Strategy* and address important issues with new legislation. Major accomplishments during the past year include:

- Bipartisan support and funding for the Youth Anti-Drug Media Campaign
- Full funding of the Drug-Free Communities Program
- Passage of the Foreign Narcotics Kingpin Designation Act, which is part of the Intelligence Authorization Act for FY2000. It provides a statutory framework for the President to institute sanctions against foreign drug kingpins in order to deny these businesses and agents access to the U.S. financial system. This new tool will enhance our ability to combat the national security threat posed by international drug trafficking.
- Congress will be briefed extensively on the achievement of the inter-agency approval for a plan to gather and utilize counterdrug intelligence, which is known as the General Counterdrug Intelligence Plan and is to be announced in early 2000.
- Continued support of the HIDTA program.

ONDCP was pleased to testify at fourteen hearings in 1999 and take part in numerous events with substantial Congressional involvement. ONDCP officials appeared before Congress on all aspects of drug control policy and implementation, including the *Strategy*, the federal drug control budget, the Youth Anti-Drug Media Campaign, emerging global threats, the drug legalization movement, reauthorization of the Safe and Drug Free Schools program, the cocaine and heroin crisis in Colombia, the Southwest border, and the use of performance-enhancing drugs in Olympic competition.

Consultation with National Drug-Control Program Agencies

ONDCP works closely with agencies that have been charged to oversee drug prevention, education, treatment, law enforcement, corrections, and interdiction. Input from fifty-two federal agencies was used to update goals and objectives; develop performance measures; and formulate budgets, initiatives, and programs. ONDCP chaired interagency demand-reduction and

supply reduction working groups. Interdiction operations were shaped by the United States Interdiction Coordinator (USIC) and the Interdiction Committee (TIC). ONDCP also coordinated the activities of U.S. members of the U.S.-Mexico High Level Contact group for Drug Control.

Consultation with State and Local Officials

ONDCP consults regularly with state and local officials when implementing the *Strategy*. Governors from all states and territories, along with state drug control agencies, provide input in the areas of prevention, treatment, and enforcement. ONDCP worked closely throughout the year with organizations like as the National Governor's Association, Council of State Governments, U.S. Conference of Mayors, and National Association of Counties to coordinate policies and programs. Perspectives were solicited from every mayor of a city with at least 100,000 people as well as key county officials. In addition, local prevention experts, treatment providers, and law enforcement officials offered "street-level" views of the drug problem along with potential solutions.

Consultation with Private Citizens and Organizations

ONDCP gathered opinions from community anti-drug coalitions, chambers of commerce, editorial boards, the entertainment industry, law enforcement and legal associations, medical associations and professionals, non-governmental organizations, and religious institutions. A list of private-sector groups whose views were considered during formulation of the *2000 Annual Report* is provided at the end of this chapter.

The World Wide Web is a rapidly growing tool for the exchange of information between ONDCP and the public. The ONDCP web site (www.whitehousedrugpolicy.gov) was accessed 2,348,674 times by 632,567 users in 1999. ONDCP-sponsored and affiliated web sites are a vital part of the National Youth Anti-Drug Media Campaign. During the past year these sites were accessed by hundreds of thousands of parents, teachers, mentors, and youth seeking reliable information. Current ONDCP-sponsored sites for parents and youth include:

- www.theantidrug.com
- www.freevibe.com
- www.mediacampaign.org

In addition, AOL, ONDCP, and the Partnership for a Drug-Free America have collaborated on an AOL Parent's Drug Resource Center at AOL Keyword: Drug Help

Consultation with Representatives of Foreign Governments and International Organizations

The United States coordinated international drug-control policies with global and regional organizations including the U.N. (particularly UNDCP), the EU, the OAS, the Caribbean Community (CARICOM), and the Association of South-East Asian Nations (ASEAN). U.S. agencies also worked in partnership with authorities in major transit and source nations to confront international criminal organizations, develop plans to stop money laundering, deny safe havens to international criminals, and protect citizens and democratic institutions from corruption or subversion.

CONSULTATION WITH NON-GOVERNMENTAL ORGANIZATIONS

Views of the following organizations were considered during formulation of the *2000 Annual Report:*

100 Black Men of America, Inc.
Academy of TV, Arts and Sciences
Addiction Research and Treatment Corporation
Ad Council
Adjutant General Association of the United States
Advertising Council
AFL-CIO
African American Parents for Drug Prevention
Alcohol and Drug Problems Association of North America
Alcohol Policy Coalition
Alcohol Policy Foundation
Alcoholics Anonymous World Services
Alianza para un Puerto Rico sin Drogas
America Cares, Inc.
America's Promise: Alliance for Youth
American Academy of Addiction Psychiatry
American Academy of Family Physicians
American Academy of Healthcare Providers in the Addictive Disorders
American Academy of Nurse Practitioners
American Academy of Pediatrics
American Academy of Physician Assistants
American Anthropological Association
American Association of Halfway House Alcoholism Programs
American Association of Health Plans
American Association of Pastoral Counselors
American Association of Preferred Provider Organizations
American Association of School Administrators
American Association of University Women
American Bar Association
American College of Emergency Physicians
American College of Neuropsychopharmacology
American College of Nurse Practitioners
American College of Physicians
American College of Preventive Medicine
American Correctional Association
American Council for Drug Education
American Counseling Association
American Enterprise Institute
American Federation of Government Employees
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Foundation for AIDS Research
American Friends Service Committee
American Judges Association
American Legion
American Managed Behavioral Healthcare Association
American Management Association
American Medical Association
American Medical Student Association
American Medical Women's Association
American Methadone Treatment Association, Inc.
American Nurses Association
American Occupational Therapy Association
American Pharmaceutical Association
American Physical Therapy Association
American Psychiatric Association
American Psychological Association
American Psychological Association
American Public Health Association
American Public Welfare Association
American Red Cross
American School Counselors Association
American Society for Pharmacology and Experimental Therapeutics
American Society of Addiction Medicine
American Speech/Language/Hearing Association
American Youth Work Center
Amnesty International
AMVETS
Annenberg School of Communications
Asian Community Mental Health Services
ASPIRA
Association for Health Services Research
Association for Hospital Medical Education
Association for Medical Education and Research in Substance Abuse (AMERSA)
Association for Worksite Health Promotion
Association of Academic Health Centers
Association of Caribbean Commissioners of Police
Association of Jesuits Colleges and Universities
Association of Junior Leagues
Association of State Correctional Administrators
Association of Southeast Asian Nations
BACCHUS and GAMMA Peer Education
Baltimore Council of Foreign Affairs
Benevolent and Protective Order of Elks
Bensinger DuPont & Associates
Big Brothers Big Sisters of America
Black Psychiatrists of America
Bodega de la Familia (New York City)
Boy Scouts of America
Boys and Girls Clubs of America
Brookings Institute
Business Roundtable
B'nai B'rith International
B'nai B'rith Youth
California Border Alliance Group
California Mentor Initiative
California Narcotics Officers Association
California School Board Association
Camp Fire Boys and Girls
Caribbean Common Market and Community
Caribbean Customs Law Enforcement Council
Carter Center
Catholic Charities U.S.A.
Center for Alcohol and Drug Research Education
Center for Health Promotion
Center for Media Education, Inc.
Center for Media Literacy
Center for Medical Fellowships in Alcoholism and Drug Abuse
Center for Science in the Public Interest
Center on Addiction and Substance Abuse of Columbia University (CASA)
Chicago Project for Violence Prevention
Child Welfare League of America, Inc.
Children's Defense Fund
Christian Life Commission
Church of Jesus Christ of Latter Day Saints
Church Women United
Cities in Schools
Civitan International
Cobb County Chamber of Commerce
College on Problems of Drug Dependence
Commission on Narcotic Drugs of the United Nations Economic and Social Council
Communitarian Network
Community Anti-Drug Coalitions of America
Community Crusade Against Drugs
Congress of National Black Churches
Consortium of Social Science Associations
Corporate Alliance for Drug Education (CADE)
Corporations Against Drug Abuse
Council of State Governments
Council on Foreign Relations
D.A.R.E. America
Delancey Street Foundation
Delta Sigma Theta Sorority
Drug Free America Foundation, Inc.
Drug Prevention Network of the Americas
Drug Strategies
Drug Watch International
Drugs Don't Work
Educational Video Center
Emergency Nurses Association
Employee Assistance Professionals Association
Employee Assistance Society of North America
Employer Health Programs

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Empower America
Entertainment Industries Council, Inc.
European Commission
Families and Schools Together (FAST)
Families U.S.A. Foundation
Family Research Council
Federal Law Enforcement Officers Association
Fellowship of Christian Athletes
Florida Alcohol and Drug Abuse Association, Inc.
Florida Chamber of Commerce
Foster Grandparents Program
Fox Children's Network
Fox News Channel
Fraternal Order of Eagles
Fraternal Order of Police
Gaudenzia Program (Pennsylvania)
Gateway Community Services
Gateway Foundation
Gay Men's Health Crisis
General Federation of Women's Clubs
Generations United
George Meany Center for Labor Studies
Georgia State University, Department of Psychology
Girl Scouts of the U.S.A.
Girls, Incorporated
Hadassah
Haight Ashbury Free Clinic
Harvard Inter-Disciplinary Working Group on Drugs and Addiction
Harvard University School of Public Health
Hazelden
Heritage Foundation
Hispanic American Command Officers Association
Hispanic American Police Officers Association
Hispanic American Police Command Officer's Association
Houston's Drug Free Business Initiative
Human Rights Watch
Illinois Drug Education Alliance
Independent Order of Odd Fellows
Institute for a Drug-Free Workplace
Inter-American College of Physicians/Surgeons
Inter-American Drug Abuse Control Commission of the Organization of American States
International Association of Campus Law Enforcement Administrators
International Association of Chiefs of Police
International Association of Junior Leagues
International Association of Women Police
International Brotherhood of Police Officers
International Brotherhood of Teamsters
International Certification and Reciprocity Consortium
International City Managers Association
International Drug Strategy Institute
International Criminal Police Organization
International Narcotic Control Board
International Narcotic Enforcement Officers Association
International Olympics Committee
International Scientific and Medical Forum on Drug Abuse
International Students in Action
Institute for Behavior and Health, Inc.
Institute for the Advancement of Social Work Research
Johns Hopkins University School of Medicine
Johnson Institute Foundation
Join Together
Junior Achievement of the National Capital Area, Inc.
Junior Chamber International, Inc.
"Just Say No" International
Kaiser Family Foundation
Kids in a Drug Free Society (K.I.D.S.)
Kiwanis International
Knights of Columbus
Latino Council on Alcohol and Tobacco
Lawyer's Committee for Human Rights
League of United Latin American Citizens
Legal Action Center
Life Steps Foundation, Inc.
Linden Grove
Lindesmith Center
Lions Club International
Little League Foundation
Los Alamos Citizens Against Substance Abuse (LACASA)
Lutte Contra La Toxicomanie
LUZ Social Services
Major City Chiefs Organization
Maryland Underage Drinking Prevention Coalition
Mediascope
Metropolitan Atlanta Crime Commission
Millenium Project
Milton Eisenhower Foundation
Milwaukee Council on Alcoholism and Drug Dependence
Moose International
Mothers Against Drunk Driving (MADD)
Nar-Anon Family Groups
Narcotics Anonymous
National Education Association
National 4-H Council
National Academy of Public Administration
National Alliance for Model State Drug Laws
National Alliance for the Mentally Ill
National Alliance of Methadone Advocates
National Alliance of Police Organizations
National Alliance of State Drug Enforcement Agencies
National Alliance of State Territorial AIDS Directors
National Asian Pacific American Families Against Substance Abuse (NAPAFASA)
National Asian Women's Health Organization
National Assembly of Voluntary Health and Social Welfare Associations
National Association for Children of Alcoholics (NACOA)
National Association for Family and Community Education
National Association for Native American Children of Alcoholics
National Association for the Advancement of Colored People
National Association of Addiction Treatment Providers
National Association of Alcoholism and Drug Abuse Counselors
National Association of Asian Pacific Islanders
National Association of Biology Teachers
National Association of Black Law Enforcement
National Association of Blacks in Criminal Justice
National Association of Black Psychologists
National Association of Chain Drug Stores
National Association of Chiefs of Police Organizations
National Association of Community Health Centers, Inc.
National Association of Counties
National Association of County and City Health Officials
National Association of County Behavioral Health Directors
National Association of Drug Court Professionals
National Association of Elementary School Principals
National Association of Governor's Councils on Physical Fitness and Sports
National Association of Managed Care Physicians
National Association of Manufacturers
National Association of Municipalities
National Association of Native American Children of Alcoholics (NANACOA)
National Association of Neighborhoods
National Association of People with AIDS
National Association of Police Organizations
National Association of Prenatal Addiction Research
National Association of Prevention Professionals and Advocates, Inc. (NAPPA)
National Association of Protection and Advocacy Systems
National Association of Psychiatric Health Systems
National Association of Regional Councils
National Association of School Nurses
National Association of Secondary School Principals
National Association of Social Workers
National Association of State Alcohol and Drug Abuse Directors
National Black Alcoholism and Addiction Council
National Black Caucus of Local Elected Officials
National Black Caucus of State Legislators
National Black Child Development Institute, Inc.
National Black Police Association
National Black Prosecutors
National Caucus of Hispanic School Board Members
National Center for Missing and Exploited Children
National Center for State Courts
National Center for Tobacco-Free Kids
National Coalition for the Homeless
National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)
National Coalition of State Alcohol and Drug Abuse Directors
National Collegiate Athletic Association
National Committee for the Furtherance of Jewish Education

National Committee to Prevent Child Abuse
National Conference of Christians and Jews
National Conference of Puerto Rican Women
National Conference of State Legislators
National Congress of Parents and Teachers
National Consortium of TASC Programs
National Consumers League
National Council for Community Behavioral Healthcare
National Council of Catholic Men
National Council of Catholic Women
National Council of Churches
National Council of Jewish Women
National Council of Juvenile and Family Court Judges
National Council of La Raza
National Council of Negro Women
National Council on Alcoholism and Drug Dependence
National Council on Disability
National Council on Patient Information and Education
National Crime Prevention Council
National Criminal Justice Association
National District Attorneys Association
National Drug Court Institute
National Drug Prevention League
National Drug Strategy Network
National Education Association
National Exchange Club
National Families in Action
National Family Partnership
National Federation of Independent Businesses
National Federation of Parents for Drug Free Youth
National Federation of State High School Associations
National FFA Organization
National Governors' Association
National Health Council
National High School Athletic Coaches Association
National Hispanic/Latino Community Prevention Network
National Hispanic Leadership Conference
National Hispanic Radio
National Indian Youth Leadership Development Project
National Inhalant Prevention Coalition
National Institute for Women of Color
National Institute of Citizen Anti-Drug Policy
National Jewish Community Relations Advisory Council
National Latino Children's Institute
National League of Cities
National League of Counties
National Legal Aid and Defenders Association
National Masonic Foundation for Children
National Medical Association
National Mental Health Association
National Mentoring Partnership
National Minority Health Association
National Narcotics Officers' Association Coalition
National Network of Runaway and Youth Services
National Nurses Society on Addiction
National Opinion Research Center
National Organization of Black County Officials
National Organization of Black Law Enforcement Executives
National Organization on Fetal Alcohol Syndrome
National Panhellenic Conference
National Parents and Teachers Association
National Pharmaceutical Association
National Pharmaceutical Council, Inc.
National Prevention Network
National Puerto Rican Coalition
National Recreation and Parks Association
National Rural Alcohol and Drug Abuse Network
National Rural Health Association
National School Boards Association
National Sheriffs' Association
National Strategy Center
National Telemedia Council
National Treatment Accountability for Safer Communities
National Treatment Consortium
National Troopers Coalition
National Urban Coalition
National Wellness Association
National Wholesale Druggists' Association
National Women's Health Resource Center
Native American Outreach Project, America Society of Internal Medicine
Neighborhood Drug Crisis Center
New York Hospital-Cornell Medical Center
New York University Medical Center
Nonprescription Drug Manufacturers Association
North American Conference of Grand Masters
Northwest Center for Health and Safety
Odyssey House
One Church - One Addict
Operation PAR, Inc.
Optimist International
Organization of American States
Organization of Chinese Americans, Inc.
Orthodox Union
Parents Collaborative
Parents' Resource Institute for Drug Education, Inc. (PRIDE)
PAR, Inc.
Partners in Drug Abuse Rehabilitation Counseling
Partnership for a Drug-Free America
Patrician Movement
Pediatric AIDS Foundation
Penn State University
Pharmaceutical Research and Manufacturers of America
Phoenix House
Physicians for Prevention (PFP)
Physicians Leadership on National Drug Policy
Pilot International
Points of Light Foundation
Police Executive Research Forum
Police Foundation
Presbyterian Women: Presbyterian Church USA
Pretrial Services Resource Center
Prevention, Intervention and Treatment Coalition for Health (PITCH)
Professional Actors' Guild
Professional Directors Guild
Professional Writers' Guild
Public Agenda, Inc.
Public Relations Society of America
Quota International
RAND Corporation
Religious Action Center
Resource Center on Substance Abuse Prevention and Disability
Robert Wood Johnson Foundation
Rotary International
Raritan National
Safe Streets
San Diego World Affairs Council
San Francisco AIDS Foundation
Scott Newman Center
Sertoma International
Sigma Gamma Rho Sorority
Siouxland Cares
Society for Applied Anthropology
Society for Neuroscience
Society for the Advancement of Women's Health Research
Society for Prevention Research
Society for Research in Child Development
Sons and Daughters in Touch
Soroptimist International of the Americas
Southern Christian Leadership Conference
State Justice Institute
Student National Medical Association
Students Against Destructive Decisions (SADD)
Substance Abuse Foundation for Education and Research (SAFER)
Substance Abuse Program Administrators Association (SAPAA)
Support Center for Alcohol and Drug Research and Education
Temple University, Department of Pharmacology,
College on Problems of Drug Dependence
Texans' War on Drugs
Texas A&M University - Department of Marketing
The Center for Drug-Free Living, Inc.
The Church of Jesus Christ of Latter-Day Saints
The Institute for Youth Development
The LINKS, Inc.
The Matrix Institute on Addictions

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The North American Committee
The Recovery Network
The Robert Wood Johnson Foundation
The Salvation Army
The Village, Inc.
Therapeutic Communities of America
Town Hall of Los Angeles
Travelers Aid International
Treatment Accountability for Safer Communities
Treatment Alternatives for Safe Communities (TASC)
Troy Michigan Communities Coalition
Twentieth Century Fund
Two Hundred Club of Greater Miami
U.S. Chamber of Commerce
U.S. Conference of Mayors
U.S. Hispanic Chamber of Commerce
U.S. Olympic Committee Union of American Hebrew Congregations
United Church of Christ
United Methodist Association of Health and Welfare
United Methodist Church, Central Pennsylvania Conference
United National Indian Tribal Youth, Inc
United Nations Economic and Social Council
United Nations International Drug Control Programme
United States Catholic Conference
United States Conference of Mayors
United Synagogue of Conservative Judaism
United Way of America
University of California, Los Angeles
Drug Abuse Research Group
Graduate School of Management
Neuropsychiatric Group
University of Delaware, Division of Criminal Justice
University of Kentucky
Center for Prevention Research and
Department of Communication
University of Maryland, Center for Substance Abuse Research (CESAR)
University of Michigan Survey Research Center
University of Nebraska Medical Center
University of North Carolina, Department of Curriculum and Instruction
University of Pennsylvania
Health System
Treatment Research Center
University of Southern California, Center for Prevention Policy Research
University of Washington, College of Education and Alcohol and Drug Abuse Institute
Urban Institute
Urban League
Veterans of Foreign Wars
Virginia Association of Alcoholism and Drug Abuse Counselors
Visiting Nurses Association of America
Washington Business Group on Health
Washington Office on Latin America
Wellness Council of America
White Bison, Inc.
World Affairs Council of San Diego
World Affairs Council of Washington, D.C.
Yale University School of Medicine
Yerkes Regional Primate Research Center, Emory University
YMCA of the USA
YWCA of the USA
Youth Service America
Youth to Youth
Zeta Phi Beta, Inc.
Zonta International

Appendix: Drug-Related Data

Up-to-date information on the availability and prevalence of illegal drugs and the criminal, health, and social consequences of their use is vital to the implementation of the *National Drug Control Strategy*. Such information is also important for measuring the effectiveness of federal, state, and local drug-control programs. The Office of National Drug Control Policy's (ONDCP) Advisory Committee on Research, Data, and Evaluation; Subcommittee on Data, Research, and Interagency Coordination (the Data Subcommittee) coordinates the development and analysis of drug-control information in support of the Strategy. The Office of National Drug Control Policy Reauthorization Act of 1998 defines ONDCP's reporting requirements to include "an assessment of current drug use (including inhalants) and availability, impact of drug use, and treatment availability." The legislation* specifies that this assessment shall include the following:

(i) estimates of drug prevalence and frequency of use as measured by national, State, and local surveys of illicit drug use and by other special studies of:

  (I) casual and chronic drug use;

  (II) high-risk populations, including school dropouts, the homeless and transient, arrestees, parolees, probationers, and juvenile delinquents; and

  (III) drug use in the workplace and the productivity lost by such use;

(ii) an assessment of the reduction of drug availability against an ascertained baseline, as measured by:

  (I) the quantities of cocaine, heroin, marijuana, methamphetamine, and other drugs available for consumption in the United States;

  (II) the amount of marijuana, cocaine, heroin, and precursor chemicals entering the United States;

  (III) the number of hectares of marijuana, poppy, and coca cultivated and destroyed domestically and in other countries;

  (IV) the number of metric tons of marijuana, heroin, cocaine, and methamphetamine seized;

  (V) the number of cocaine and methamphetamine processing laboratories destroyed domestically and in other countries;

  (VI) changes in the price and purity of heroin and cocaine, changes in the price of methamphetamine, and changes in tetrahydrocannabinol level of marijuana;

  (VII) the amount and type of controlled substances diverted from legitimate retail and wholesale sources; and

  (VIII) the effectiveness of Federal technology programs at improving drug detection capabilities in interdiction, and at United States ports of entry;

(iii) an assessment of the reduction of the consequences of drug use and availability, which shall include estimation of:

  (I) the burden drug users placed on hospital emergency departments in the United States, such as the quantity of drug-related services provided;

  (II) the annual national health care costs of drug use, including costs associated with people becoming infected with the human immunodeficiency virus and other infectious diseases as a result of drug use;

* The text is quoted directly from PL 105-277.

(III) the extent of drug-related crime and criminal activity; and

(VI) the contribution of drugs to the underground economy as measured by the retail value of drugs sold in the United States;

(iv) a determination of the status of drug treatment in the United States, by assessing:

(I) public and private treatment capacity within each State, including information on the treatment capacity available in relation to the capacity actually used;

(II) the extent, within each State, to which treatment is available;

(III) the number of drug users the Director estimates could benefit from treatment; and

(IV) the specific factors that restrict the availability of treatment services to those seeking it and proposed administrative or legislative remedies to make treatment available to those individuals; and

(v) a review of the research agenda of the Counter-Drug Technology Assessment Center to reduce the availability and abuse of drugs.

Data are available for many of the areas listed above; however, there are specific areas for which measurement systems are not yet fully operational. The tables presented in this appendix contain the most current drug-related data on the areas the 1998 ONDCP Reauthorization Act requires ONDCP to assess.

Improving Federal Drug-Related Data Systems

ONDCP is supporting an initiative to develop a comprehensive data system to inform drug policy makers. It will support all ninety-seven targets that constitute the *Strategy's* Performance Measures of Effectiveness (PME) system. The ONDCP-coordinated Data Subcommittee is reviewing existing data systems to identify "data gaps" and determine what modifications can be made to enhance the system. SAMHSA, for example, is increasing the sample size and scope of the NHSDA to provide state-by-state data and greater information about drug use among twelve to seventeen-year-olds. More frequent estimates of the social costs of drug abuse will be made. ONDCP is continuing the development of a "cocaine flows" estimate model.

This initiative will improve the policy relevance of federal drug-related data systems by bringing them into alignment with the PME system. The Data Subcommittee has supported the following innovations:

- The National Institute of Justice expanding and revising of the Drug Use Forecasting program into the Arrestee Drug Abuse Monitoring (ADAM) system. Plans call for the expansion of ADAM to seventy-five sites with probability-based samples representative of the respective metropolitan areas. The new ADAM instrument will include questions to promote the estimation of the prevalence of drug abuse among arrestee populations comparable to those generated for the general household population. The first ten new ADAM sites were funded by ONDCP in 1998.
- SAMHSA enlarged the sample for the National Household Survey on Drug Abuse – reaching nearly triple the size – permitting, for the first time, estimation of drug use prevalence at the state level. The first wave of new data will be available in August 2000.
- SAMHSA/CSAT is expected in FY 2001 to fund the implementation of the National Treatment Outcome Monitoring System (NTOMS). NTOMS will combine the work of two existing data systems currently funded by ONDCP: the Drug Evaluation Network System, which provides real-time data on treatment admission; and the Random Access Monitoring of Narcotics Addicts system, which estimates the size and characteristics of chronic drug-using populations. NTOMS will provide essential data for the PME system on treatment, waiting time, and chronic users.
- SAMHSA/CSAP has several activities to promote state data systems. For example, twenty states now voluntarily collect common process and capacity data using software developed under Minimum Data Set I (MDSI), which permits collection from the provider through the substate, state, and federal system levels. Similarly, states can voluntarily report on five common outcome measures, consistent with ONDCP PMEs, in the pilot SAPT block grant application for FY2000.

ONDCP is currently leading an interagency effort to develop drug-flow models – from source countries through availability in the United States – for cocaine, heroin, marijuana, and methamphetamine. Results from

this project are providing critical measures for the PME system, enabling assessment of the nation's supply-reduction programs.

Data Source Descriptions

The following sections provide brief descriptions of the major data sources used to develop this appendix.

What America's Users Spend on Illegal Drugs: 1988–1998 (Source for Tables 1, 3, 41, and 47)

This report estimates total U.S. expenditures on illicit drugs based on available drug supply and demand data. Data are provided on estimated numbers of users, yearly, and weekly expenditures for drugs, trends in drug supply, and retail prices of drugs. Abt Associates, Inc. first wrote the report for ONDCP in 1993. It was updated in 1995, 1997, and 1999.

National Household Survey on Drug Abuse (Source for Tables 2 and 4)

The National Household Survey on Drug Abuse (NHSDA) measures the prevalence of drug and alcohol use among household members aged twelve and older. Topics include drug use, health, and demographics. In 1991, the NHSDA was expanded to include college students in dormitories, persons living in homeless shelters, and civilians living on military bases. The NHSDA was administered by the National Institute on Drug Abuse (NIDA) from 1974 through 1991; the Substance Abuse and Mental Health Services Administration (SAMHSA) has administered the survey since 1992.

Monitoring the Future: A Continuing Study of the Lifestyles and Values of Youth (Source for Tables 5 and 6)

Often referred to as the "High School Senior Survey," the *Monitoring the Future* (MTF) study provides information on drug use trends as well as changes in values, behaviors, and lifestyle orientations of American youth. The study examines drug-related issues, including recency of drug use, perceived harmfulness of drugs, disapproval of drug use, and perceived availability of drugs. Although the focus of the MTF study has been high school seniors and graduates who complete follow-up surveys, eighth and tenth graders were added to the study sample in 1991. The University of Michigan has conducted the study under a grant from NIDA since 1975.

Youth Risk Behavior Survey (Source for Tables 7, 8, 9, 10, 12, and 14)

The Youth Risk Behavior Survey (YRBS) is a component of the Youth Risk Behavior Surveillance System (YRBSS), maintained by the Centers for Disease Control and Prevention (CDC). The YRBSS currently has the following three complementary components: (1) national school-based surveys, (2) state and local school-based surveys, and (3) a national household-based survey. Each of these components provides unique information about various sub-populations of adolescents in the United States. The school-based survey was initiated in 1990, and the household-based survey was conducted in 1992. The school-based survey is conducted biennially in odd-numbered years throughout the decade among national probability samples of ninth through twelfth graders from public and private schools. Schools with a large proportion of black and Hispanic students are over sampled to provide stable estimates for these subgroups. The 1992 Youth Risk Behavior Supplement was administered to one in-school youth and up to two out-of-school youths in each family selected for the National Health Interview Survey. In 1992, 10,645 youth aged twelve to twenty-one were included in the YRBS sample. The purpose of the supplement was to provide information on a broader base of youth, including those not currently attending school, than usually is obtained with surveys and to obtain accurate information on the demographic characteristics of the household in which the youth reside. Another component of the YRBSS is the national Alternative High School Youth Risk Behavior Survey (ALT-YRBS). Conducted in 1998, ALT-YRBS results are based on a nationally representative sample of 8,918 students enrolled in alternative high schools, who are at high risk for failing or dropping out of regular high school or who have been expelled from regular high school because of illegal activity or behavioral problems.

PRIDE USA Survey (Source for Table 11)

The National Parent's Resource Institute for Drug Education (PRIDE) conducts an annual survey of drug use by middle school and high school students. The PRIDE survey collects data from students in sixth through twelfth grades and is conducted during the school year between September and June. Participating schools are sent the questionnaires with detailed instructions for administering the anonymous, self-report instrument. Schools participate on a voluntary basis or in compliance with a school or state request. The study conducted during the 1998–99 school year involved approximately 135,000 students in 28 states.

Current Population Survey (Source for Table 13)

As mandated by the U.S. Constitution, Article 1, Section 2, the U.S. Bureau of the Census has conducted a census every ten years since 1790. The primary purpose of the census is to provide population counts needed to apportion seats in the U.S. House of Representatives and subsequently determine state legislative district boundaries. The information collected also provides insight on population size and a broad range of demographic background information on the population living in each geographic area. The individual information in the census is grouped together into statistical totals. Information such as the number of persons in a given area, their ages, educational background, and the characteristics of their housing enable government, business, and industry to plan more effectively.

The Monetary Value of Saving a High-Risk Youth (Source for Tables 15 and 16)

Based on estimates of the social costs associated with the typical career criminal, the typical drug user, and the typical high school dropout, this study calculates the average monetary value of saving a high risk youth. The base data for establishing the estimates are derived from other studies and official crime data that provide information on numbers and types of crimes committed by career criminals, as well as the costs associated with these crimes and with drug abuse and dropping out of school.

Arrestee Drug Abuse Monitoring/Drug Use Forecasting Program (Source for Tables 17 through 22)

The National Institute of Justice established the Drug Use Forecasting (DUF) program in 1987 to provide an objective assessment of the drug problem among those arrested and charged with crimes. In 1997 this program became the Arrestee Drug Abuse Monitoring (ADAM) program. The ADAM program collected data in thirty-five major metropolitan sites across the United States in 1998, up from twenty-three in 1997. Arrestees are interviewed and asked to provide urine specimens that are tested for evidence of drug use. Urinalysis results can be matched to arrestee characteristics to help monitor trends in drug use. The sample size of the data set varies from site to site. The majority of sites each collect data from 300 to 700 adult male arrestees, 100 to 300 female arrestees (at thirty-two sites), and 150 to 300 juvenile male arrestees (at thirteen sites). Together, the 1998 data comprised 20,716 adult male arrestees, 6,700 adult female arrestees, and 3,134 juvenile male arrestees. The ADAM system is expanding to more cities in the coming years.

Substance Abuse among Probationers and State and Federal Prisoners (Source for Table 23)

Conducted by the Bureau of Justice Statistics, Office of Justice Programs, Department of Justice, the 1997 Survey on Inmates in State and Federal Correctional Facilities comprises 14,285 interviews for the state survey and 4,041 for the federal survey using computer assisted personal interviewing (published in December 1998). The survey is conducted every five to six years. The first national survey of adults on probation was conducted in 1995 by BJS and provides information on drug use from personal interviews with a national representative sample of over 2,000 adult probationers under active supervision (published in March 1998).

Homelessness: Programs and the People They Serve (Source for Tables 24 to 26)

The National Survey of Homeless Assistance Providers and Clients provides a full picture of homeless service users in late 1996. It provides updated information about the providers of homeless assistance services and the characteristics of homeless clients who use these services. Information from this survey was intended for use by federal agencies responsible for administering homeless assistance programs and other interested parties. The survey was conceived, developed, and funded by twelve federal agencies under the auspices of the Interagency Council on the Homeless, a working group of the White House Domestic Policy Council. The Census Bureau carried out the data collection on behalf of the sponsoring agencies. The Survey, released in December 1999, provides the first opportunity since 1987 to update the national picture of homelessness in a comprehensive and reliable way.

The Economic Costs of Alcohol and Drug Abuse in the United States (Source for Table 27)

The NIDA and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) commissioned this study to estimate the economic costs of alcohol and drug abuse in the United States. The study, which was released in 1998, is based on 1992 data and includes estimates for 1995. Before this report, the last complete cost estimate using detailed data was for 1985.

National Vital Statistics Report (Source for Table 28)

Data on drug-induced deaths are based on information from all death certificates filed (2.3 million in 1997) in the fifty states and the District of Columbia. Information from the states is provided to the National Center for Health Statistics (NCHS), a component of CDC. NCHS tabulates causes of death attributable to drug-induced mortality, including drug psychoses, drug dependence, nondependent drug use not including alcohol and tobacco, accidental poisoning by drugs, medicaments and biologicals, suicide by drugs, medicaments and biologicals, assault from poisoning by drugs and medicaments, and poisoning by drugs, medicaments, and biologicals, undetermined whether accidentally or purposely inflicted. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mother's drug use.

Drug Abuse Warning Network (Source for Table 29)

The Drug Abuse Warning Network (DAWN) provides data on drug related emergency department episodes and medical examiner cases. DAWN assists federal, state, and local drug policy makers to examine drug use patterns and trends and assess health hazards associated with drug abuse. Data are available on deaths and emergency department episodes by type of drug, reason for taking the drug, demographic characteristics of the user, and metropolitan area. NIDA maintained DAWN from 1982 through 1991; SAMHSA has maintained it since 1992.

HIV/AIDS Surveillance Report (Source for Tables 30 and 31)

The HIV/AIDS Surveillance Reports contain tabular and graphic information about U.S. AIDS and HIV case reports, including data by state, metropolitan statistical area, mode of exposure to HIV, sex, race/ethnicity, age group, vital status, and case definition category. The Division of HIV/AIDS Prevention, National Center for HIV, STD, and TB Prevention, a component of CDC, publishes it semi-annually. Data on mode of exposure to HIV are of interest to the Strategy in light of the role of injection drug use in HIV transmission.

Reported Tuberculosis in the United States (Source for Table 32)

The TB Surveillance Reports contain tabular and graphic information about reported tuberculosis cases collected from 59 reporting areas (the 50 states, the District of Columbia, New York City, U.S. dependencies and possessions, and independent nations in free association with the United States). The reports include statistics on tuberculosis case counts and case rates by states and metropolitan statistical areas with tables of selected demographic and clinical characteristics (e.g., race/ethnicity, age group, country of origin, form of disease, drug resistance, etc). The Division of TB Elimination, National Center for HIV, STD and TB Prevention, a component of CDC, publishes the reports annually. The reports also include information on injection drug use and non-injection drug use among TB cases.

Summary of Notifiable Diseases (Source for Table 33)

This publication contains summary tables of the official statistics for the reported occurrence of nationally notifiable diseases in the United States, including hepatitis. These statistics are collected and compiled from reports to the National Notifiable Diseases Surveillance System, which is operated by CDC in collaboration with the Council of State and Territorial Epidemiologists. These data are finalized and published in CDC's Morbidity and Mortality Weekly Review *Summary of Notifiable Diseases, United States* for use by state and local health departments; schools of medicine and public health; communications media; local, state, and federal agencies; and other agencies or persons interested in following the trends of reportable diseases in the United States. The annual publication of the Summary also documents which diseases are considered national priorities for notification and the annual number of cases of such diseases.

Uniform Crime Reports (Source for Tables 34 and 35)

The Uniform Crime Reports (UCR) is a nationwide census of thousands of city, county, and state law-enforcement agencies. The goal of the UCR is to count in a standardized manner the number of offenses, arrests, and clearances known to police. Each law-enforcement agency voluntarily reports data on crimes. Data are reported for the following nine index offenses: murder and manslaughter, forcible rape, robbery, aggravated assault, burglary, larceny, theft, motor vehicle theft, and arson. Data on drug arrests, including arrests for possession, sale, and manufacturing of drugs, are included in the database. Distributions of arrests for drug abuse violations by demographics and geographic areas also are available. UCR data have been collected since 1930; the FBI has collected data under a revised system since 1991.

Survey of Inmates of Local Jails (Source for Table 36)

The Survey of Inmates of Local Jails provides nationally representative data on inmates held in local jails, including those awaiting trials or transfers and those serving sentences. Survey topics include inmate characteristics, offense histories, drug use, and drug treatment. The Bureau of Justice Statistics (BJS) has conducted the survey every five to six years since 1972.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities (Source for Table 36)

The Survey of Inmates in Federal Correctional Facilities (SIFCF) and Survey of Inmates in State Correctional Facilities (SISCF) provide comprehensive background data on inmates in federal and state correctional facilities, based on confidential interviews with a sample of inmates. Topics include current offenses and sentences, criminal histories, family and personal backgrounds, gun possession and use, prior alcohol and drug treatment, and educational programs and other services provided in prison. The SIFCF and SISCF were sponsored jointly in 1991 by the BJS and the Bureau of Prisons and conducted by the Census Bureau. Similar surveys of state prison inmates were conducted in 1974, 1979, and 1986. The most recent SIFCF and SISCF were conducted in 1997.

National Prisoner Statistics Program (Source for Table 36)

The National Prisoner Statistics Program provides an advance count of federal, state, and local prisoners immediately after the end of each calendar year, with a final count published by the BJS later in the year.

Uniform Facility Data Set/National Drug and Alcoholism Treatment Unit Survey (Source for Tables 37, 38 and 40)

The Uniform Facility Data Set (UFDS) measures the location, scope, and characteristics of drug abuse and alcoholism treatment facilities throughout the United States. The survey collects data on unit ownership, type, and scope of services provided; sources of funding; number of clients; treatment capacities; and utilization rates. Data are reported for a point prevalence date in the fall of the year in which the survey is administered. Many questions focus on the twelve months prior to that date. The UFDS, then called the National Drug and Alcoholism Treatment Unit Survey (NDATUS), was administered jointly by NIDA and the National Institute of Alcohol Abuse and Alcoholism from 1974 to 1991. Since 1992 SAMHSA has administered UFDS.

National Drug Treatment Requirements (Source for Table 39)

The U.S. Department of Health and Human Services (HHS) is mandated by Congress to report to the Office of Management and Budget on its goals for enrolling drug abusers in treatment facilities and the progress it has made in achieving those goals. HHS provides data on the estimated number of clients who receive treatment, as well as persons who need treatment but are not in treatment.

System To Retrieve Information From Drug Evidence (Source for Table 42)

The System To Retrieve Information From Drug Evidence (STRIDE) compiles data on illegal substances purchased, seized, or acquired in DEA investigations. Data are gathered on the type of drug seized or bought, drug purity, location of confiscation, street price of the drug, and other characteristics. Data on drug exhibits from the FBI; the Metropolitan Police Department of the District of Columbia; and some exhibits submitted by other federal, state, and local agencies also are included in STRIDE. STRIDE data have been compiled by DEA since 1971.

Federal-Wide Drug Seizure System (Source for Table 43)

The Federal Wide Drug Seizure System (FDSS) is an online computerized system that stores information about drug seizures made within the jurisdiction of the United States by the DEA, FBI, Customs Service, and Coast Guard. The FDSS database includes drug seizures by other Federal agencies (e.g., the Immigration and Naturalization Service) to the extent that custody of the drug evidence was transferred to one of the four agencies identified above. The database includes information from STRIDE, the Customs Law Enforcement Activity Report, and the U.S. Coast Guard's Law Enforcement Information System. The FDSS has been maintained by the DEA since 1988.

International Narcotics Control Strategy Report (Source for Tables 46, 49 to 55)

The International Narcotics Control Strategy Report (INCSR) provides the President with information on the steps taken by the main illicit drug-producing and transiting countries to prevent drug production, trafficking, and related money laundering during the previous year. The INCSR helps determine how cooperative a country has been in meeting legislative requirements in various geographic areas. Production estimates by source country also are provided.

Estimating Cocaine Flow: The Sequential Transition and Reduction (STAR) Model, 1996-1998 (Source for Table 48)

ONDCP is developing a flow model for cocaine, called the Sequential Reduction and Transition (STAR) Model. The STAR model takes each of four point-estimates and uses transition matrices to estimate availability at all the other stages. These four independent measures are: (1) potential production estimate, an imagery-based estimate of the coca crop combined with and coca cultivation studies, (2) Interagency Cocaine Movement Assessment estimate, an event-based estimate of cocaine departing source areas, (3) an estimate of cocaine crossing the U.S. border based on the allocation of domestic resources and interdiction efficiency, and (4) a domestic consumption estimate. As a result, availability estimates at each stage of cocaine's movement, from source to consumer, are a composite of point-estimates. Abt Associates, Inc. prepared a report describing this model for ONDCP in 1999.

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DRUG USER EXPENDITURES

Table 1. Total U.S. Expenditures on Illicit Drugs, 1988–98 ($ Billions)

Year	Cocaine	Heroin	Marijuana	Meth-amphetamine	Other drugs	Total
1988	$76.9	$21.8	$11.3	$2.4	$3.3	$115.7
1989	70.8	20.9	11.1	2.4	2.8	108.0
1990	61.3	17.6	13.5	2.4	2.2	97.0
1991	55.0	13.8	12.8	2.0	2.3	85.9
1992	49.4	10.9	12.5	1.6	1.5	75.9
1993	45.9	10.2	11.2	1.7	1.5	70.5
1994	42.2	10.5	11.4	2.1	2.6	68.6
1995	43.0	11.2	9.3	2.5	2.7	66.8
1996	41.3	11.7	9.0	2.1	2.7	66.8
1997	41.8	12.2	10.1	1.8	2.5	68.4
1998	39.0	11.6	10.7	1.5	2.3	65.0
1999*	37.1	12.0	10.2	1.7	2.3	63.2

* Estimates for 1999 are projections.

Note: Amounts are in constant 1998 dollars.

Source: Office of National Drug Control Policy. 1999. *What America's Users Spend on Illegal Drugs, 1988–1998.*

DRUG USE

Table 2. Trends in Selected Drug Use Indicators, 1979–98

Selected drug use indicators	Any illicit drug use[1]	Current cocaine use[1]	Occasional (less than monthly) cocaine use	Current marijuana use[1]	Lifetime heroin use	Any adolescent[2] illicit drug use[1]	Lifetime adolescent[2] inhalant use[3]
			Millions of Users				
1979	25.4	4.7	—	23.8	2.3	4.1	—
1982	—	4.5	—	21.5	1.8	2.8	—
1985	23.3	5.7	7.1	18.6	1.8	3.2	—
1988	15.2	3.1	5.1	12.4	1.7	1.9	—
1990	13.5	1.7	3.7	10.9	1.5	1.6	—
1991	13.4	2.0	3.8	10.4	2.4	1.4	—
1992	12.0	1.4	3.0	9.7	1.7	1.3	—
1993	12.3	1.4	2.7	9.6	2.1	1.4	—
1994	12.6	1.4	2.4	10.1	2.1	1.8	1.5
1995	12.8	1.5	2.5	9.8	2.5	2.4	1.6
1996	13.0	1.7	2.6	10.1	2.4	2.0	1.3
1997	13.9	1.5	2.6	11.1	2.0	2.6	1.6
1998	13.6	1.8	2.4	11.0	2.4	2.3	1.4
			Rate of Use (Percent)				
1979	14.1	2.6	—	13.2	1.3	16.3	—
1982	—	2.4	—	11.5	1.0	—	—
1985	12.1	3.0	3.7	9.7	0.9	13.2	—
1988	7.7	1.6	2.6	6.2	0.9	8.1	—
1990	6.7	0.9	1.8	5.4	0.8	7.1	—
1991	6.6	1.0	1.9	5.1	1.2	5.8	—
1992	5.8	0.7	1.5	4.7	0.8	5.3	—
1993	5.9	0.7	1.3	4.6	1.0	5.7	—
1994	6.0	0.7	1.2	4.8	1.0	8.2	7.0
1995	6.1	0.7	1.2	4.7	1.2	10.9	7.4
1996	6.1	0.8	1.2	4.7	1.1	9.0	5.9
1997	6.4	0.7	1.2	5.1	0.9	11.4	7.2
1998	6.2	0.8	1.1	5.0	1.1	9.9	6.1

— Data not available.

[1] Data are for past month (current) use.

[2] Ages 12 to 17 years.

[3] Prior to a 1994 questionnaire change, data do not allow separate reporting for this age group.

Note: Any illicit drug use includes use of marijuana, cocaine, hallucinogens, inhalants, (except in 1982), heroin, or nonmedical use of sedatives, tranquilizers, stimulants, or analgesics. The exclusion of inhalants in 1982 is believed to have resulted in under estimates of any illicit use for that year, especially for adolescents.

Source: *National Household Survey on Drug Abuse*, National Institute on Drug Abuse (1979–91), and Substance Abuse and Mental Health Services Administration (1992–98).

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Table 3. Estimated Number of Hardcore and Occasional Users of Cocaine and Heroin (Thousands), 1988–95

Year	Cocaine users		Heroin users	
	Occasional[1]	Hardcore[2]	Occasional[1]	Hardcore[2]
1988	6,000	3,873	170	923
1989	5,300	3,315	150	886
1990	4,600	3,186	140	797
1991	4,478	3,170	395	681
1992	3,503	3,259	304	630
1993	3,332	3,350	230	694
1994	2,930	3,367	281	795
1995	3,082	3,555	428	855
1996	3,425	3,410	455	917
1997	3,487	3,503	597	935
1998	3,216	3,343	253	980
1999*	2,411	3,348	484	977

Note: Data in this table are preliminary composite estimates derived from the *National Household Survey on Drug Abuse* (NHSDA) and the *Drug Use Forecasting* (DUF) program (see W. Rhodes "Synthetic Estimation Applied to the Prevalence of Drug Use," *Journal of Drug Issues*, 23(2):297–321, 1993 for a detailed description of the methodology). The NHSDA was not administered in 1989. Estimates for 1989 are the average for 1988 and 1989.

* Estimates for 1999 are projections.

[1] "Occasional" means used less often than weekly.

[2] "Hardcore" means used at least weekly.

Source: Office of National Drug Control Policy, 1999. *What America's Users Spend on Illegal Drugs, 1988–1998.*

Table 4. Drug Use by Current Employment Status,[1] 1995–98 (Percent Prevalence)

	Full-time	Part-time	Unemployed	Other[2]
Past Month Use of Any Illicit Drug				
1995	5.5	9.0	14.3	3.1
1996	6.2	8.6	12.5	3.0
1997	6.5	7.7	13.8	3.0
1998	6.4	7.4	18.2	2.8
Past Month Use of Marijuana				
1995	4.2	7.5	12.6	1.9
1996	4.9	6.2	10.0	2.3
1997	5.0	6.6	12.2	2.4
1998	5.1	6.5	15.1	2.0
Past Month Use of Cocaine				
1995	0.7	0.8	2.1	0.4
1996	0.9	1.1	2.4	0.4
1997	0.7	0.9	2.4	0.3
1998	0.9	0.5	3.4	0.4

— Data not available.

[1] Data on current employment are for persons aged 18 and older.

[2] Retired, disabled, homemaker, student, or "other."

Source: *National Household Survey on Drug Abuse*, National Institute on Drug Abuse (1979–91), and Substance Abuse and Mental Health Services Administration (1992–98).

Table 5. Trends in 30-Day Prevalence of Selected Drugs Among 8th, 10th, and 12th Graders, 1991–99

Selected drug/grade	30-Day Prevalence (Percent)									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1998–99 Change
Marijuana/hashish										
8th grade	3.2	3.7	5.1	7.8	9.1	11.3	10.2	9.7	9.7	0.0
10th grade	8.7	8.1	10.9	15.8	17.2	20.4	20.5	18.7	19.4	+0.7
12th grade	13.8	11.9	15.5	19.0	21.2	21.9	23.7	22.8	23.1	+0.3
Inhalants[1, 2]										
8th grade	4.4	4.7	5.4	5.6	6.1	5.8	5.6	4.8	5.0	+0.2*
10th grade	2.7	2.7	3.3	3.6	3.5	3.3	3.0	2.9	2.6	–0.3
12th grade	2.4	2.3	2.5	2.7	3.2	2.5	2.5	2.3	2.0	–0.3
Hallucinogens[3]										
8th grade	0.8	1.1	1.2	1.3	1.7	1.9	1.8	1.4	1.3	–0.1
10th grade	1.6	1.8	1.9	2.4	3.3	2.8	3.3	3.2	2.9	–0.3
12th grade	2.2	2.1	2.7	3.1	4.4	3.5	3.9	2.8	3.5	–0.3
LSD										
8th grade	0.6	0.9	1.0	1.1	1.4	1.5	1.5	1.1	1.1	0.0
10th grade	1.5	1.6	1.6	2.0	3.0	2.4	2.8	2.7	2.3	–0.4
12th grade	1.9	2.0	2.4	2.6	4.0	2.5	3.1	3.2	2.7	–0.5
Cocaine										
8th grade	0.5	0.7	0.7	1.0	1.2	1.3	1.1	1.4	1.3	–0.1
10th grade	0.7	0.7	0.9	1.2	1.7	1.7	2.0	2.1	1.8	–0.3
12th grade	1.4	1.3	1.3	1.5	1.8	2.0	2.3	2.4	2.6	+0.2
Stimulants										
8th grade	2.6	3.3	3.6	3.6	4.2	4.6	3.8	3.3	3.4	–0.1
10th grade	3.3	3.6	4.3	4.5	5.3	5.5	5.1	5.1	5.0	–0.1
12th grade	3.2	2.8	3.7	4.0	4.0	4.1	4.8	4.6	4.5	–0.1
Alcohol (any use)[4]										
8th grade	25.1	26.1	24.3	25.5	24.6	26.2	24.5	23.0	24.0	+1.0
10th grade	42.8	39.9	38.2	39.2	38.8	40.4	40.1	38.8	40.0	+1.2
12th grade	54.0	51.3	48.6	50.1	51.3	50.8	52.7	52.0	51.0	–1.0

= 0.05 level of significance of 1997–98 difference. Any apparent inconsistency between the 1997–98 change estimate and the respective prevalence estimates is due to rounding error.

Approximate Ns	1991	1992	1993	1994	1995	1996	1997	1998	1999
8th grade	17,500	18,600	18,300	17,300	17,500	17,800	18,600	18,100	16,700
10th grade	14,800	14,800	15,300	15,800	17,000	15,600	15,500	15,000	13,600
12th grade	15,000	15,800	16,300	15,400	15,400	14,300	15,400	15,200	13,600

For 12th graders only. Data based on five of six questionnaire forms; N is five-sixths of N indicated.

Unadjusted for underreporting of amyl and butyl nitrites.

Unadjusted for underreporting of PCP (phencyclidine).

For all grades: In 1993, the question text was changed slightly in one-half of the forms to indicate that a "drink" meant "more than a few sips." In 1993, N is one-half of N indicated for all groups. Data after 1993 were based on all forms for all grades.

Source: *Monitoring the Future* study, Institute for Social Research, University of Michigan (December 1999).

Table 6. Trends in Harmfulness of Drugs as Perceived by 8th, 10th, and 12th Graders, 1991–99

Drug	Percentage saying "great risk"[1]									
	1991	1992	1993	1994	1995	1996	1997	1998	1999	1998–99 Change
8th grade										
How much do you think people risk harming themselves (physically or in other ways), if they . . .										
• Try marijuana once or twice	40.4	39.1	36.2	31.6	28.9	27.9	25.3	28.1	28.0	0.0
• Smoke marijuana occasionally	57.9	56.3	53.8	48.6	45.9	44.3	43.1	45.0	45.7	+0.7
• Smoke marijuana regularly	83.8	82.0	79.6	74.3	73.0	70.9	72.7	73.0	73.9	+0.3
• Try crack once or twice[2]	62.8	61.2	57.2	54.4	50.8	51.0	49.9	49.3	48.7	-0.6
• Take crack occasionally[2]	82.2	79.6	76.8	74.4	72.1	71.6	71.2	70.6	70.6	0.0
• Try cocaine powder once or twice[2]	55.5	54.1	50.7	48.4	44.9	45.2	45.0	44.0	43.3	-0.6
• Take cocaine powder occasionally[2]	77.0	74.3	71.8	69.1	66.4	65.7	65.8	65.2	65.4	+0.1
Approximate N	17,437	18,662	18,366	17,394	17,501	17,926	18,765	18,100	16,700	
10th grade										
How much do you think people risk harming themselves (physically or in other ways), if they . . .										
• Try marijuana once or twice	30.0	31.9	29.7	24.4	21.5	20.0	18.8	19.6	19.2	-0.4
• Smoke marijuana occasionally	48.6	48.9	46.1	38.9	35.4	32.8	31.9	32.5	33.5	+1.0
• Smoke marijuana regularly	82.1	81.1	78.5	71.3	67.9	65.9	65.9	65.8	65.9	+0.2
• Try crack once or twice	70.4	69.6	66.6	64.7	60.9	60.9	59.2	58.0	57.8	-0.1
• Take crack occasionally	87.4	86.4	84.4	83.1	81.2	80.3	78.7	77.5	79.1	+1.7
• Try cocaine powder once or twice	59.1	59.2	57.5	56.4	53.5	53.6	52.2	50.9	51.6	+0.7
• Take cocaine powder occasionally	82.2	80.1	79.1	77.8	75.6	75.0	73.9	71.8	73.6	+1.8
Approximate N	14,719	14,808	15,298	15,880	17,006	15,670	15,640	15,000	13,600	
12th grade										
How much do you think people risk harming themselves (physically or in other ways), if they . . .										
• Try marijuana once or twice	27.1	24.5	21.9	19.5	16.3	15.6	14.9	16.7	15.7	-1.0
• Smoke marijuana occasionally	40.6	39.6	35.6	30.1	25.6	25.9	24.7	24.4	23.9	-0.5
• Smoke marijuana regularly	78.6	76.5	72.5	65.0	60.8	59.9	58.1	58.5	57.4	-1.1
• Try crack once or twice	60.6	62.4	57.6	58.4	54.6	56.0	54.0	52.2	48.2	-4.0*
• Take crack occasionally	76.5	76.3	73.9	73.8	72.8	71.4	70.3	68.7	67.3	-1.4
• Try cocaine powder once or twice	53.6	57.1	53.2	55.4	52.0	53.2	51.4	48.5	46.1	-2.4
• Take cocaine powder occasionally	69.8	70.8	68.6	70.6	69.1	68.8	67.7	65.4	64.2	-1.2
Approximate N	2,549	2,684	2,759	2,591	2,603	2,449	2,579	2,500	2,300	

Note: * = 0.05 level of significance of 1998–99 difference. Any apparent inconsistency between the 1998–99 change estimate and the respective prevalence estimates is due to rounding error.

[1] Answer alternatives were: (1) no risk, (2) slight risk, (3) moderate risk, (4) great risk, and (5) can't say, drug unfamiliar.

[2] 8th and 10th grade: Beginning in 1997, data based on two-thirds of N indicated due to changes in questionnaire forms.

Source: *Monitoring the Future* study, Institute for Social Research, University of Michigan (December 1999).

Table 7. Percentage of High School Students Who Used Selected Drugs by Sex and Grade, 1990, 1991, 1993, 1995, and 1997

Behavior and grade	Both sexes					Male					Female				
	1990	1991	1993	1995	1997	1990	1991	1993	1995	1997	1990	1991	1993	1995	1997
Lifetime marijuana use															
9th	20.6	—	24.4	33.8	38.8	—	—	28.8	38.9	41.3	—	—	19.7	27.9	36.1
10th	27.9	—	28.8	41.4	45.9	—	—	30.9	43.2	48.1	—	—	26.7	39.5	43.3
11th	34.7	—	36.0	45.8	50.3	—	—	40.8	48.0	55.6	—	—	30.8	43.6	43.8
12th	42.2	—	40.8	47.0	52.4	—	—	45.5	50.4	56.1	—	—	35.8	43.8	47.7
All grades	31.4	31.0	32.8	42.4	47.1	35.9	33.0	36.8	46.2	50.7	27.0	30.0	28.6	39.4	42.9
Current marijuana use[1]															
9th	9.5	—	13.2	20.9	23.6	—	—	16.3	23.9	26.8	—	—	9.7	17.3	20.1
10th	13.5	—	16.5	25.6	25.0	—	—	18.2	28.2	28.5	—	—	14.7	22.6	20.9
11th	13.9	—	18.4	27.6	29.3	—	—	22.1	30.1	34.7	—	—	14.4	25.1	22.9
12th	18.5	—	22.0	26.2	26.6	—	—	25.0	30.8	30.3	—	—	18.9	21.6	21.9
All grades	13.9	15.0	17.7	25.3	26.2	16.9	17.0	20.6	28.4	30.2	11.1	12.0	14.6	22.0	21.4
Lifetime cocaine use[2]															
9th	3.6	—	4.2	5.7	6.7	—	—	4.6	7.2	6.6	—	—	3.8	3.9	6.8
10th	5.8	—	3.7	7.5	7.5	—	—	3.9	8.5	8.5	—	—	3.5	6.4	6.3
11th	7.6	—	5.1	7.2	9.1	—	—	5.5	9.4	10.1	—	—	4.5	4.8	7.9
12th	9.3	—	6.1	7.4	9.2	—	—	7.5	10.0	10.5	—	—	4.6	4.9	7.6
All grades	6.6	6.0	4.9	7.0	8.2	8.1	7.0	5.5	8.8	9.1	5.2	4.0	4.2	5.0	7.2
Current cocaine use[1]															
9th	1.0	—	1.6	3.1	3.9	—	—	2.2	4.8	4.1	—	—	1.0	1.2	3.6
10th	2.4	—	1.4	2.5	2.6	—	—	1.7	2.2	3.6	—	—	1.0	2.9	1.5
11th	2.5	—	2.1	3.6	3.1	—	—	2.4	5.3	3.7	—	—	1.7	1.8	2.2
12th	2.3	—	2.1	3.1	3.5	—	—	2.5	4.9	4.5	—	—	1.6	1.3	2.2
All grades	2.1	2.0	1.9	3.1	3.3	3.3	2.0	2.3	4.3	4.0	1.0	1.0	1.4	1.8	2.4
Lifetime crack or freebase use															
9th	—	—	2.7	4.7	5.1	—	—	2.7	6.1	5.7	—	—	2.7	3.1	4.5
10th	—	—	2.3	4.9	4.3	—	—	2.1	5.4	4.2	—	—	2.5	4.3	4.4
11th	—	—	2.7	4.4	4.8	—	—	3.1	5.8	5.6	—	—	2.1	2.8	3.9
12th	—	—	2.6	4.2	4.7	—	—	3.6	5.1	5.2	—	—	1.6	3.4	4.0
All grades	—	—	2.6	4.5	4.7	—	—	3.0	5.6	5.2	—	—	2.2	3.4	4.2
Lifetime use of illegal steroids															
9th	—	—	2.1	4.1	4.3	—	—	2.7	4.7	4.7	—	—	1.4	3.4	3.9
10th	—	—	2.0	3.6	3.0	—	—	2.4	4.2	4.1	—	—	1.6	3.1	1.7
11th	—	—	2.2	3.9	2.7	—	—	3.2	5.5	4.2	—	—	1.0	2.2	0.9
12th	—	—	2.3	2.9	2.5	—	—	3.5	4.8	3.3	—	—	1.0	1.0	1.4
All grades	—	3.0	2.2	3.7	3.1	—	4.0	3.1	4.9	4.1	—	1.0	1.2	2.4	2.0
Lifetime injected drug use															
9th	—	—	1.4	2.8	3.0	—	—	1.9	3.8	3.3	—		0.8	1.6	2.5
10th	—	—	1.4	2.2	2.5	—	—	1.5	2.7	2.7	—	—	1.4	1.7	2.2
11th	—	—	1.3	1.7	1.6	—	—	1.9	2.8	2.4	—	—	0.6	0.5	0.7
12th	—	—	1.2	1.6	1.5	—	—	1.9	2.8	2.0	—	—	0.4	0.4	0.8
All grades	—	—	1.4	2.0	2.1	—	—	1.9	3.0	2.6	—	—	0.8	1.0	1.5
Episodic heavy drinking[3]															
9th	27.7	—	22.0	24.5	25.7	—	—	24.0	27.6	25.5	—	—	19.7	20.2	25.8
10th	35.7	—	26.2	30.3	29.9	—	—	27.2	32.1	32.7	—	—	25.3	28.3	26.3
11th	39.6	—	31.3	34.9	37.5	—	—	37.1	37.8	45.2	—	—	25.1	31.8	28.2
12th	44.0	—	39.1	39.0	39.3	—	—	45.0	46.5	44.0	—	—	33.0	31.6	33.6
All grades	36.9	31.0	30.0	32.6	33.4	43.5	36.0	33.7	36.2	37.3	30.4	26.0	26.0	28.6	28.6

— Data not available.

[1] Used one or more times during the last 30 days.

[2] Ever tried any form of cocaine, including powder, crack, or freebase.

[3] Drank 5 or more drinks of alcohol on at least one occasion on 1 or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Tobacco, Alcohol and Other Drug Use Among High School Students—United States," 40, no. 45 (1990): 776–84, 41, no. 37 (1991): 698–703; *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

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Table 8. Percentage of High School Students Who Used Selected Drugs by Race/Ethnicity, 1993, 1995, and 1997

Behavior and race/ethnicity	Both sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Lifetime marijuana use									
White, non-Hispanic	32.7	40.5	45.4	36.0	42.7	48.3	29.3	38.1	41.9
Black, non-Hispanic	33.6	47.2	52.2	41.1	54.2	59.3	26.3	42.0	45.4
Hispanic	35.4	49.2	49.5	41.5	53.2	54.7	29.5	46.4	43.2
All groups	32.8	42.4	47.1	36.8	46.2	50.7	28.6	39.4	42.9
Current marijuana use[1]									
White, non-Hispanic	17.3	24.6	25.0	19.7	26.8	28.0	14.7	22.1	21.2
Black, non-Hispanic	18.6	28.6	28.2	24.3	36.8	35.6	13.0	22.1	21.4
Hispanic	19.4	27.8	28.6	23.2	32.2	33.1	15.7	23.5	23.3
All groups	17.7	25.3	26.2	20.6	28.4	30.2	14.6	22.0	21.4
Lifetime cocaine use[2]									
White, non-Hispanic	4.6	6.5	8.0	5.3	8.2	8.5	3.9	4.6	7.5
Black, non-Hispanic	1.6	2.0	1.9	1.9	3.9	2.9	1.2	0.5	1.0
Hispanic	11.3	16.0	14.4	12.1	17.0	16.1	10.4	15.0	12.5
All groups	4.9	7.0	8.2	5.5	8.8	9.1	4.2	5.0	7.2
Current cocaine use[1]									
White, non-Hispanic	1.6	2.6	3.1	2.0	3.7	3.7	1.2	1.4	2.3
Black, non-Hispanic	1.0	1.3	0.7	1.5	2.7	1.2	0.5	0.2	0.2
Hispanic	4.6	7.5	6.2	6.2	9.3	6.9	3.0	5.8	5.3
All groups	1.9	3.1	3.3	2.3	4.3	4.0	1.4	1.8	2.4
Lifetime crack or freebase use									
White, non-Hispanic	2.3	4.2	4.5	2.6	5.4	4.7	2.0	2.9	4.3
Black, non-Hispanic	1.1	1.6	1.2	1.6	3.2	1.5	0.6	0.3	0.9
Hispanic	6.3	10.5	8.0	7.1	9.4	8.2	5.5	11.6	7.7
All groups	2.6	4.5	4.7	3.0	5.6	5.2	2.2	3.4	4.2
Lifetime use of illegal steroids									
White, non-Hispanic	1.9	3.8	3.1	2.8	5.3	3.9	1.0	2.2	2.0
Black, non-Hispanic	2.4	1.6	1.5	4.0	2.4	2.3	0.8	0.9	0.7
Hispanic	3.0	4.7	3.4	3.4	4.1	3.9	2.6	5.3	2.8
All groups	2.2	3.7	3.1	3.1	4.9	4.1	1.2	2.4	2.0
Lifetime injected drug use									
White, non-Hispanic	1.3	2.0	1.8	1.8	2.8	2.2	0.7	1.1	1.3
Black, non-Hispanic	0.9	1.1	1.0	1.4	2.1	1.6	0.4	0.3	0.4
Hispanic	1.5	2.2	2.2	1.8	3.5	2.9	1.1	0.9	1.3
All groups	1.4	2.0	2.1	1.9	3.0	2.6	0.8	1.0	1.5
Episodic heavy drinking[3]									
White, non-Hispanic	32.6	35.6	37.7	35.6	38.6	41.6	29.3	32.2	32.9
Black, non-Hispanic	19.1	18.8	16.1	25.1	24.9	21.0	13.3	13.0	11.5
Hispanic	33.4	37.7	34.9	39.4	39.4	40.0	27.6	36.1	26.8
All groups	30.0	32.6	33.4	33.7	36.2	37.3	26.0	28.6	28.6

[1] Used one or more times during the last 30 days.

[2] Ever tried any form of cocaine, including powder, crack, or freebase.

[3] Drank 5 or more drinks of alcohol on at least one occasion on 1 or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 9. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors on School Property, by Sex and Grade, 1993, 1995, and 1997

Behavior and grade	Both Sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Used marijuana on school property[1]									
9th	4.4	8.7	8.1	5.9	11.2	9.6	2.8	5.8	6.5
10th	6.5	9.8	6.4	9.2	12.9	8.2	3.6	6.6	4.2
11th	6.5	8.6	7.9	8.7	12.0	10.2	4.0	4.9	5.2
12th	5.1	8.0	5.7	7.3	11.2	8.2	2.7	4.7	2.6
All grades	5.6	8.8	7.0	7.8	11.9	9.0	3.3	5.5	4.6
Offered, sold, or were given an illegal drug on school property[2]									
9th	21.8	31.0	31.4	24.6	35.8	34.5	18.4	24.9	28.0
10th	23.7	35.0	33.4	27.9	43.0	40.0	19.2	26.4	25.3
11th	27.5	32.8	33.2	32.9	39.8	38.8	21.7	25.3	26.4
12th	23.0	29.1	29.0	28.2	36.2	36.4	17.5	22.0	19.6
All grades	24.0	32.1	31.7	28.5	38.8	37.4	19.1	24.8	24.7
Tried marijuana before age 13									
9th	–	9.2	14.9	–	12.0	18.9	–	5.9	10.6
10th	–	9.1	10.4	–	12.1	12.2	–	5.9	8.3
11th	–	6.7	8.3	–	8.6	11.3	–	4.7	4.6
12th	–	5.4	5.8	–	8.0	7.6	–	2.8	3.6
All grades	–	7.6	9.7	–	10.2	12.2	–	4.8	6.7
Tried cocaine before age 13[3]									
9th	–	1.3	1.8	–	1.8	1.9	–	0.6	1.8
10th	–	1.3	1.3	–	1.8	1.3	–	0.7	1.3
11th	–	1.4	1.0	–	2.4	1.7	–	0.3	0.3
12th	–	0.9	0.3	–	1.3	0.5	–	0.5	0.2
All grades	–	1.2	1.1	–	1.8	1.3	–	0.5	0.8

– Data not available.
[1] One or more times during the 30 days preceding the survey.
[2] During the 12 months preceding the survey.
[3] Including powder, crack, and freebase forms of cocaine.
Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 10. Percentage of High School Students Who Reported Engaging in Drug-Related Behaviors, by Sex and Race/Ethnicity, 1993, 1995, and 1997

Behavior and race/ethnicity	Both Sexes			Male			Female		
	1993	1995	1997	1993	1995	1997	1993	1995	1997
Used marijuana on school property[1]									
White, non-Hispanic	5.0	7.0	5.8	7.1	9.7	7.3	2.8	4.0	3.9
Black, non-Hispanic	7.3	12.3	9.1	10.1	17.6	13.0	4.5	8.1	5.4
Hispanic	7.5	12.9	10.4	10.0	17.6	14.1	4.9	8.3	5.9
All groups	5.6	8.8	7.0	7.8	11.9	9.0	3.3	5.5	4.6
Offered, sold, or were given an illegal drug on school property[2]									
White, non-Hispanic	24.1	31.7	31.0	28.8	38.8	36.1	18.9	23.5	24.5
Black, non-Hispanic	17.5	28.5	25.4	20.3	35.3	34.6	14.8	22.5	16.7
Hispanic	34.1	40.7	41.1	41.5	46.7	46.8	26.8	34.9	34.4
All groups	24.0	32.1	31.7	28.5	38.8	37.4	19.1	24.8	24.7
Tried marijuana before age 13									
White, non-Hispanic	–	5.6	7.5	–	7.8	9.0	–	3.2	5.6
Black, non-Hispanic	–	11.1	11.0	–	16.5	15.6	–	6.7	6.5
Hispanic	–	12.6	13.2	–	16.5	17.2	–	8.8	8.3
All groups	–	7.6	9.7	–	10.2	12.2	–	4.8	6.7
Tried cocaine before age 13[3]									
White, non-Hispanic	–	0.9	0.9	–	1.4	1.1	–	0.4	0.7
Black, non-Hispanic	–	1.3	0.4	–	2.4	0.7	–	0.3	0.1
Hispanic	–	1.7	1.4	–	2.0	1.8	–	1.3	1.0
All groups	–	1.2	1.1	–	1.8	1.3	–	0.5	0.8

– Data not available.
[1] Used marijuana one or more times during the last 30 days.
[2] During the past 12 months.
[3] Including powder, crack, and freebase forms of cocaine.
Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—United States (1993, 1995, and 1997)," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

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Table 11. Prevalence of Monthly Drug Use Among 6th–8th, 9th–12th, and 12th graders, 1994–95 through 1998-99

	Monthly use (Percent)					
	1994–95	1995–96	1996–97	1997–98	1998-99	Change*
Cigarettes						
6th–8th	15.7	17.2	17.3	15.6	13.2	–2.4
9th–12th	31.3	33.4	34.7	33.9	31.1	–2.8
12th	34.6	36.2	38.3	40.7	37.5	–3.2
Beer						
6th–8th	11.8	12.5	12.1	10.7	10.2	–0.5
9th–12th	33.3	34.3	34.4	31.9	31.5	–0.4
12th	40.6	41.2	41.7	41.0	39.9	–1.1
Wine coolers						
6th–8th	9.8	10.8	10.8	9.9	9.6	–0.3
9th–12th	23.1	22.3	22.3	21.4	22.9	+1.5
12th	25.6	22.9	23.7	23.9	25.5	+1.6
Liquor						
6th–8th	8.5	9.0	9.1	8.0	8.0	0.0
9th–12th	27.4	28.2	28.7	26.9	28.1	+1.2
12th	32.5	32.8	34.0	34.1	35.3	+1.2
Marijuana						
6th–8th	5.7	8.1	8.6	7.1	6.5	–0.6
9th–12th	18.5	22.3	22.7	20.8	20.3	–0.5
12th	20.9	24.3	24.4	23.6	23.1	–0.5
Cocaine						
6th–8th	1.2	1.5	1.7	1.6	1.5	–0.1
9th–12th	2.6	2.9	3.0	3.1	3.2	+0.1
12th	2.9	3.6	3.6	4.0	4.1	+0.1
Uppers						
6th–8th	2.0	2.4	2.6	2.5	2.1	–0.4
9th–12th	5.1	5.2	5.3	5.4	5.0	–0.4
12th	5.6	5.8	5.6	6.3	5.8	–0.5
Downers						
6th–8th	1.5	1.9	2.1	1.9	1.7	–0.2
9th–12th	3.4	3.8	3.8	4.2	4.0	–0.2
12th	3.6	4.1	3.9	4.9	4.5	–0.4
Inhalants						
6th–8th	2.9	3.5	3.7	3.3	2.7	–0.6
9th–12th	3.5	3.4	3.1	3.1	3.0	–0.1
12th	3.0	3.1	2.7	2.8	3.0	+0.2
Hallucinogens						
6th–8th	1.5	1.8	2.0	1.8	1.7	–0.1
9th–12th	4.1	4.5	4.2	3.9	4.2	+0.3
12th	4.8	5.1	4.6	4.5	5.2	+0.7

* Difference between the 1997–98 and 1998–99 surveys.

	Sample sizes				
Grade	1994–95	1995–96	1996–97	1997–98	1998–99
6th–8th	92,453	58,596	68,071	68,149	57,006
9th–12th	105,788	70,964	73,006	86,201	77,699
12th	20,698	14,261	15,532	15,816	16,093

Table 12. Percentage of Alternative High School Students Who Used Selected Drugs by Sex, Race/Ethnicity, and Grade, 1998

Drug Use Behavior	SEX		RACE/ETHNICITY			GRADE LEVEL				ALL GROUPS
	Male	Female	White, non-Hispanic	Black, non-Hispanic	Hispanic	9th	10th	11th	12th	
Lifetime marijuana	88.0	82.1	89.4	77.7	84.0	81.0	85.3	86.0	86.8	85.4
Current marijuana[1]	58.2	46.7	56.7	47.2	50.6	51.2	52.9	55.7	51.2	53.0
Lifetime cocaine use[2]	38.6	33.0	43.8	5.7	46.4	32.7	36.4	37.8	36.5	36.1
Current cocaine use[1]	17.1	13.1	17.1	3.6	19.4	14.8	16.6	15.9	14.1	15.3
Lifetime crack or freebase use	23.5	19.4	26.2	3.5	26.8	20.9	22.9	24.2	18.9	21.6
Lifetime use of illegal steroids	9.8	7.4	10.5	6.6	6.9	12.0	9.6	6.9	7.6	8.7
Lifetime injected drug use	6.8	4.4	7.0	4.1	4.5	7.6	5.6	5.4	4.9	5.7
Episodic heavy drinking[3]	55.4	42.9	58.7	28.4	52.4	43.8	48.1	51.5	51.7	49.8
Current cigarette[1]	67.7	59.8	78.6	43.3	53.0	64.5	64.3	64.8	62.2	64.1

— Data not available.

[1] Used one or more times during the last 30 days.

[2] Ever tried any form of cocaine, including powder, crack, or freebase.

[3] Drank 5 or more drinks of alcohol on at least one occasion on 1 or more days during the last 30 days.

Source: *Morbidity and Mortality Weekly Report*, "Youth Risk Behavior Surveillance—National Alternative High School Youth Risk Behavior Survey, United States, 1998," Centers for Disease Control and Prevention, Public Health Service, Department of Health and Human Services.

Table 13. Dropout Rates for Persons 18 to 24 Years Old by Sex and Race/Ethnicity, 1980–96

	All races, both sexes			All races, male			All races, female			White, both sexes			White, male			White, female		
	All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1996	24,671	3,147	12.8	12,285	1,628	13.2	12,386	1,519	12.3	19,676	2,458	12.5	9,897	1,275	12.9	9,778	1,182	12.1
1995	24,900	3,471	13.9	12,351	1,791	14.5	12,548	1,679	13.4	19,866	2,711	13.6	9,980	1,430	14.3	9,886	1,281	13.0
1994	25,254	3,365	13.3	12,557	1,804	14.4	12,696	1,561	12.3	20,171	2,553	12.7	10,123	1,377	13.6	10,048	1,175	11.7
1993	25,552	3,349	13.1	12,712	1,745	13.7	12,810	1,604	12.5	20,493	2,595	12.7	10,294	1,388	13.5	10,199	1,207	11.8
1992	24,278	3,083	12.7	11,965	1,617	13.5	12,313	1,466	11.9	19,671	2,398	12.2	9,744	1,300	13.3	9,928	1,098	11.1
1991	24,572	3,486	14.2	12,036	1,810	15.0	12,536	1,676	13.4	19,980	2,845	14.2	9,896	1,520	15.4	10,119	1,324	13.1
1990	24,852	3,379	13.6	12,134	1,689	13.9	12,718	1,690	13.3	20,393	2,751	13.5	10,053	1,430	14.2	10,340	1,322	12.8
1989	25,261	3,644	14.4	12,325	1,941	15.7	12,936	1,702	13.2	20,825	2,926	14.1	10,240	1,572	15.4	10,586	1,354	12.8
1988	25,733	3,749	14.6	12,491	1,950	15.6	13,242	1,799	13.5	21,261	3,012	14.2	10,380	1,594	15.4	10,881	1,418	13.0
1987	25,950	3,751	14.5	12,626	1,948	15.4	13,324	1,803	13.5	21,493	3,042	14.2	10,549	1,593	15.1	10,944	1,449	13.2
1986	26,512	3,664	13.8	12,921	1,937	15.0	13,591	1,741	12.8	22,008	2,974	13.5	10,803	1,581	14.6	11,205	1,393	12.4
1985	27,122	3,687	13.9	13,199	2,015	15.3	13,923	1,804	13.0	22,632	3,050	13.5	11,108	1,637	14.7	11,524	1,413	12.3
1984	28,031	4,142	14.8	13,744	2,184	15.9	14,287	1,958	13.7	23,347	3,281	14.1	11,521	1,744	15.1	11,826	1,535	13.0
1983	28,580	4,410	15.4	14,003	2,379	17.0	14,577	2,031	13.9	23,899	3,428	14.3	11,787	1,865	15.8	12,112	1,563	12.9
1982	28,846	4,500	15.6	14,083	2,329	16.5	14,763	2,171	14.7	24,206	3,523	14.6	11,874	1,810	15.2	12,332	1,713	13.0
1981	28,965	4,520	15.6	14,127	2,424	17.2	14,838	2,097	14.1	24,486	3,590	14.7	12,040	1,960	16.3	12,446	1,629	13.1
1980	28,957	4,515	15.6	14,107	2,390	16.9	14,851	2,124	14.3	24,482	3,525	14.4	12,011	1,883	15.7	12,471	1,642	13.2

	Black, both sexes			Black, male			Black, female			Hispanic origin,* both sexes			Hispanic origin,* male			Hispanic origin,* female		
	All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts		All persons	High school dropouts	
		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate		Number	Rate
1996	3,637	581	16.0	1,682	292	17.4	1,956	288	14.7	3,510	1,210	34.5	1,815	657	36.2	1,694	554	32.7
1995	3,625	522	14.4	1,660	235	14.2	1,965	287	14.6	3,603	1,250	34.7	1,907	653	34.2	1,696	598	35.4
1994	3,661	568	15.5	1,733	303	17.5	1,928	265	13.7	3,523	1,224	34.7	1,896	685	36.1	1,628	539	33.1
1993	3,666	600	16.4	1,703	266	15.6	1,965	337	17.2	3,363	1,103	32.8	1,710	591	34.6	1,652	510	30.9
1992	3,521	575	16.3	1,676	259	15.5	1,845	315	17.1	2,754	936	33.9	1,384	531	38.4	1,369	405	29.6
1991	3,504	545	15.6	1,635	252	15.4	1,869	296	15.8	2,874	1,139	39.6	1,503	668	44.4	1,372	473	34.5
1990	3,520	530	15.1	1,634	223	13.6	1,886	306	16.2	2,749	1,025	37.3	1,403	559	39.8	1,346	455	34.5
1989	3,559	583	16.4	1,654	307	18.6	1,905	277	14.5	2,818	1,062	37.7	1,439	580	40.3	1,377	482	35.0
1988	3,568	631	17.7	1,653	312	18.9	1,915	318	16.6	2,642	1,046	39.6	1,375	553	40.2	1,267	492	38.8
1987	3,603	611	17.0	1,666	312	18.7	1,937	298	15.4	2,592	849	32.8	1,337	461	34.5	1,256	387	30.8
1986	3,665	605	16.6	1,687	300	17.8	1,966	311	15.8	2,514	864	34.4	1,339	500	37.4	1,175	365	31.1
1985	3,716	655	17.6	1,720	323	18.8	1,996	332	16.6	2,221	700	31.5	1,132	405	35.8	1,091	295	27.0
1984	3,862	712	18.4	1,811	362	20.2	2,052	349	17.0	2,018	691	34.2	956	338	35.4	1,061	353	33.2
1983	3,865	832	21.5	1,807	435	24.1	2,058	398	19.3	2,025	759	37.5	968	396	40.9	1,057	363	34.3
1982	3,872	851	22.0	1,786	458	25.6	2,086	393	18.8	2,001	740	37.0	944	347	36.8	1,056	393	37.2
1981	3,778	821	21.7	1,730	419	24.2	2,049	402	19.6	2,052	790	38.5	988	428	43.3	1,064	362	34.0
1980	3,721	876	23.5	1,690	440	26.0	2,031	436	21.5	2,033	820	40.3	1,012	431	42.6	1,021	389	38.1

Notes: Data for 1980 through 1992 use 1980 census-based population estimates; data for 1993 through 1996 use 1990 census-based population estimates; data for previous years are adjusted; numbers are in thousands.

* Persons of Hispanic origin may be of any race.

Source: U.S. Bureau of the Census, *Current Population Survey* (1980-1996).

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Table 14. Past-Month Drug Use for Youth Ages 12–21, by Age, Dropout Status, Type of Drug Used, and Race/Ethnicity: 1992 Youth Risk Behavior Survey (Percent Prevalence)

Race/ethnicity	Age	Dropout status	Marijuana use past 30 days	Cocaine use past 30 days
White	12–15	Nondropout	4.02	0.34
		Dropout	4.12	*
	16–21	Nondropout	15.93	1.61
		Dropout	27.60	4.12
Black	12–15	Nondropout	1.21	—
		Dropout	16.21	—
	16–21	Nondropout	13.24	1.00
		Dropout	20.80	4.40
Hispanic	12–15	Nondropout	3.96	0.81
		Dropout	*	*
	16–21	Nondropout	14.92	2.89
		Dropout	11.56	2.83
Other	12–15	Nondropout	4.56	*
		Dropout	*	*
	16–21	Nondropout	5.85	*
		Dropout	*	—

*Low precision, no estimate reported.
— No respondents.

Source: National Health Interview Survey/Youth Risk Behavior Survey, Centers for Disease Control and Prevention, National Center for Heal Statistics, 1992.

Table 15. The Lifetime Costs of Dropping Out of High School (1993 Dollars)

	Total costs	Present value (2% discount rate)	Present value (10% discount rate)
Lost wage/productivity	$360,000	$186,500	$15,300
Fringe benefits	$90,000	$46,600	$3,800
Nonmarket losses	$113,000–450,000	$58,300–233,200	$4,900–19,200
Total	$563,000–900,000	$291,000–466,000	$24,000–38,300

Note: Numbers may not add due to rounding.

Source: Cohen, Mark. *The Monetary Value of Saving a High Risk Youth*, 1995.

Table 16. Summary of the Monetary Value of Saving a High-Risk Youth

	Total costs ($ thousands)	Present value with 2% discount rate ($ thousands)	Present value with 10% discount rate ($ thousands)
Career criminal	1,200–1,500	1,000–1,300	650–850
Heavy drug user	435–1,051	333–809	159–391
High school dropout	563–900	291–466	24–38
LESS duplication (crimes committed by heavy drug users)	(252–696)	(196–540)	(96–264)
Total	1,900–2,700	1,500–2,000	700–1,000

Note: Numbers may not add correctly due to rounding.

Source: Cohen, Mark. *The Monetary Value of Saving a High Risk Youth*, 1995.

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Table 17. Percentage[1] of Adult Booked Arrestees Who Used Any Drug,[2] by Sex: 1991–98

	Males								Females							
	1991	1992	1993	1994	1995	1996	1997	1998	1991	1992	1993	1994	1995	1996	1997	1998
Albuquerque	—	—	—	—	—	—	—	65	—	—	—	—	—	—	—	73
Anchorage	—	—	—	—	—	—	—	43	—	—	—	—	—	—	—	58
Atlanta	63	69	72	69	74	80	72	66	70	65	74	72	68	77	74	—
Birmingham	63	64	68	69	73	70	67	67	62	59	55	63	57	59	67	74
Chicago	74	69	81	79	79	82	80	74	—	—	—	—	—	—	—	72
Cleveland	56	64	64	66	65	67	64	65	79	74	77	82	71	70	57	58
Dallas	56	59	62	57	60	63	63	63	56	66	61	63	58	58	53	49
Denver	50	60	64	67	66	71	71	69	54	61	66	68	66	69	69	69
Des Moines	—	—	—	—	—	—	—	57	—	—	—	—	—	—	—	67
Detroit	55	58	63	66	67	66	62	68	68	72	76	62	78	69	69	60
Ft. Lauderdale	61	64	61	58	58	67	73	74	64	62	60	62	60	66	68	67
Houston	65	59	59	48	58	64	63	60	59	54	53	48	50	54	45	52
Indianapolis	45	52	60	69	64	74	63	67	54	50	58	69	72	72	67	67
Laredo	—	—	—	—	—	—	—	57	—	—	—	—	—	—	—	33
Las Vegas	—	—	—	—	—	—	—	57	—	—	—	—	—	—	—	70
Los Angeles	62	67	66	66	62	64	59	64	75	72	77	72	68	78	70	71
Miami	68	68	70	66	57	67	61	62	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	63	—	—	—	—	—	—	—	44
New Orleans	59	60	62	63	66	67	67	67	50	52	47	32	50	35	40	51
New York City[3]	73	77	78	82	83	78	79	77	77	85	83	90	84	83	81	82
Oklahoma City	—	—	—	—	—	—	—	69	—	—	—	—	—	—	—	—
Omaha	36	48	54	59	54	63	62	60	—	—	—	58	56	51	54	60
Philadelphia	74	78	76	76	76	69	67	79	75	78	79	76	77	81	75	77
Phoenix	42	47	62	65	63	59	64	63	61	63	62	67	63	65	66	71
Portland	61	60	63	65	65	66	71	72	68	73	74	74	68	74	78	74
Sacramento	—	—	—	—	—	—	—	71	—	—	—	—	—	—	—	73
St. Louis	59	64	68	74	77	75	74	72	54	70	69	76	69	73	70	69
Salt Lake City	—	—	—	—	—	—	—	60	—	—	—	—	—	—	—	69
San Antonio	49	54	55	52	51	57	52	56	45	44	42	39	41	44	37	38
San Diego	75	77	78	79	72	71	73	69	73	72	78	76	73	62	73	64
San Jose	56	50	54	55	52	48	51	48	52	56	51	61	50	53	53	42
Seattle	—	—	—	—	—	—	—	65	—	—	—	—	—	—	—	81
Spokane	—	—	—	—	—	—	—	62	—	—	—	—	—	—	—	68
Tucson	—	—	—	—	—	—	—	63	—	—	—	—	—	—	—	57
Washington, DC	59	60	60	64	64	66	69	65	75	72	71	67	65	58	57	65

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

[3] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 18. Percentage[1] of Adult Booked Arrestees Who Used Marijuana, by Sex: 1991–98

	Males								Females							
	1991	1992	1993	1994	1995	1996	1997	1998	1991	1992	1993	1994	1995	1996	1997	1998
Albuquerque	—	—	—	—	—	—	—	36	—	—	—	—	—	—	—	24
Anchorage	—	—	—	—	—	—	—	33	—	—	—	—	—	—	—	23
Atlanta	12	22	26	25	32	37	36	26	8	13	16	15	13	26	28	—
Birmingham	16	22	28	28	36	44	43	39	10	13	12	17	12	22	25	18
Chicago	23	26	40	38	41	47	48	42	—	—	—	—	—	—	—	20
Cleveland	12	17	23	28	29	37	46	37	7	11	13	16	11	22	22	27
Dallas	19	28	29	33	37	44	44	43	11	24	19	22	21	44	28	24
Denver	25	34	36	39	33	42	42	41	16	19	24	22	21	27	32	30
Des Moines	—	—	—	—	—	—	—	42	—	—	—	—	—	—	—	15
Detroit	18	27	37	38	42	46	44	47	4	11	10	16	18	19	28	22
Ft. Lauderdale	28	32	30	29	33	38	38	44	14	21	20	18	18	24	24	25
Houston	17	24	24	23	29	33	24	36	8	12	15	13	18	26	17	20
Indianapolis	23	35	42	39	38	51	44	45	22	26	25	22	24	31	30	31
Laredo	—	—	—	—	—	—	—	39	—	—	—	—	—	—	—	13
Las Vegas	—	—	—	—	—	—	—	26	—	—	—	—	—	—	—	22
Los Angeles	19	23	23	20	23	30	27	27	9	13	15	12	14	38	18	22
Miami	23	30	26	28	29	34	32	29	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	45	—	—	—	—	—	—	—	23
New Orleans	16	19	25	28	32	40	38	38	7	8	14	7	16	13	12	22
New York City[2]	18	22	21	24	28	38	32	39	11	12	19	15	16	19	25	23
Oklahoma City	—	—	—	—	—	—	—	53	—	—	—	—	—	—	—	—
Omaha	26	38	42	44	42	52	33	44	—	—	—	28	24	33	33	28
Philadelphia	18	26	32	32	34	39	41	45	14	15	20	18	20	21	21	24
Phoenix	22	22	31	29	29	28	30	32	14	15	20	22	19	22	21	25
Portland	33	28	30	27	29	35	38	37	28	17	17	19	16	26	19	23
Sacramento	—	—	—	—	—	—	—	44	—	—	—	—	—	—	—	28
St. Louis	16	21	28	36	39	52	48	50	8	11	15	15	18	29	31	32
Salt Lake City	—	—	—	—	—	—	—	37	—	—	—	—	—	—	—	29
San Antonio	20	28	32	30	34	39	34	41	9	16	16	15	16	19	17	18
San Diego	33	35	40	36	35	40	38	36	20	25	25	20	20	23	24	27
San Jose	25	24	27	30	27	27	29	25	13	18	17	18	12	19	17	14
Seattle	—	—	—	—	—	—	—	35	—	—	—	—	—	—	—	38
Spokane	—	—	—	—	—	—	—	43	—	—	—	—	—	—	—	27
Tucson	—	—	—	—	—	—	—	39	—	—	—	—	—	—	—	22
Washington, DC	11	20	26	30	32	40	39	38	6	8	9	10	18	23	19	29

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

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Table 19. Percentage[1] of Adult Booked Arrestees Who Used Cocaine, by Sex: 1991–98

	Males								Females							
	1991	1992	1993	1994	1995	1996	1997	1998	1991	1992	1993	1994	1995	1996	1997	1998
Albuquerque	—	—	—	—	—	—	—	39	—	—	—	—	—	—	—	59
Anchorage	—	—	—	—	—	—	—	20	—	—	—	—	—	—	—	50
Atlanta	57	58	59	57	57	59	51	51	66	58	68	62	62	63	61	—
Birmingham	52	49	51	50	49	43	39	41	44	46	41	50	48	39	49	57
Chicago	61	56	53	57	51	52	49	45	—	—	—	—	—	—	—	56
Cleveland	48	53	48	48	42	41	27	37	76	66	69	74	63	52	39	41
Dallas	43	41	44	35	31	32	32	29	45	48	43	46	44	36	34	30
Denver	30	38	41	40	44	44	40	40	41	50	47	51	52	53	50	50
Des Moines	—	—	—	—	—	—	—	18	—	—	—	—	—	—	—	24
Detroit	41	37	34	34	30	27	23	28	62	62	64	46	61	53	48	46
Ft. Lauderdale	44	46	43	41	39	44	51	50	55	47	45	52	50	52	57	53
Houston	56	41	41	29	40	39	40	36	52	44	43	36	32	34	29	37
Indianapolis	22	23	32	47	39	42	31	34	26	25	36	58	54	52	45	43
Laredo	—	—	—	—	—	—	—	37	—	—	—	—	—	—	—	33
Las Vegas	—	—	—	—	—	—	—	24	—	—	—	—	—	—	—	35
Los Angeles	44	52	48	48	44	44	38	43	62	58	59	53	49	56	49	45
Miami	61	56	61	56	42	52	46	47	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	27	—	—	—	—	—	—	—	29
New Orleans	50	49	48	47	47	46	46	46	42	44	37	25	37	26	32	39
New York City[2]	62	62	66	68	68	56	58	47	66	72	70	80	71	69	62	67
Oklahoma City	—	—	—	—	—	—	—	27	—	—	—	—	—	—	—	—
Omaha	14	16	19	26	19	24	21	25	—	—	—	34	30	28	17	36
Philadelphia	62	63	56	54	51	40	34	45	64	67	61	61	59	69	58	61
Phoenix	20	26	30	28	27	32	32	31	45	49	38	36	33	42	33	40
Portland	30	35	33	32	30	34	37	29	40	54	47	43	40	46	45	37
Sacramento	—	—	—	—	—	—	—	18	—	—	—	—	—	—	—	31
St. Louis	48	50	50	50	51	43	41	35	47	62	62	69	57	55	53	44
Salt Lake City	—	—	—	—	—	—	—	20	—	—	—	—	—	—	—	20
San Antonio	31	32	31	31	24	28	26	27	25	25	24	22	24	23	18	20
San Diego	45	45	37	30	28	27	21	19	40	37	36	18	28	22	23	20
San Jose	33	28	23	19	18	16	14	8	30	32	19	23	16	21	16	10
Seattle	—	—	—	—	—	—	—	36	—	—	—	—	—	—	—	57
Spokane	—	—	—	—	—	—	—	18	—	—	—	—	—	—	—	32
Tucson	—	—	—	—	—	—	—	39	—	—	—	—	—	—	—	41
Washington, DC	49	44	37	38	35	33	33	33	68	64	62	55	46	40	39	40

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

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Table 20. Percentage[1] of Adult Booked Arrestees Who Used Opiates, by Sex: 1991–98

	Males								Females							
	1991	1992	1993	1994	1995	1996	1997	1998	1991	1992	1993	1994	1995	1996	1997	1998
Albuquerque	—	—	—	—	—	—	—	8	—	—	—	—	—	—	—	15
Anchorage	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	4
Atlanta	3	4	3	2	3	3	2	1	4	5	4	4	3	3	3	—
Birmingham	5	3	4	4	2	4	5	4	11	4	4	3	3	6	5	18
Chicago	21	19	28	27	22	20	22	18	—	—	—	—	—	—	—	27
Cleveland	3	3	4	3	5	3	4	6	6	5	4	4	6	6	4	1
Dallas	4	4	4	3	5	5	4	2	9	8	10	7	5	5	5	5
Denver	2	2	4	4	5	5	4	4	2	5	6	5	6	5	6	3
Des Moines	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—	6
Detroit	8	8	8	7	7	7	5	7	11	15	14	13	15	18	9	22
Ft. Lauderdale	1	1	1	1	2	2	3	2	4	3	3	3	3	3	4	5
Houston	3	3	2	3	5	8	10	8	4	4	4	6	3	4	5	7
Indianapolis	3	4	4	3	2	3	3	2	11	7	4	5	7	3	3	5
Laredo	—	—	—	—	—	—	—	11	—	—	—	—	—	—	—	0
Las Vegas	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—	14
Los Angeles	10	10	9	10	7	6	6	6	18	13	14	12	10	17	11	9
Miami	2	2	2	2	3	1	2	2	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	5	—	—	—	—	—	—	—	6
New Orleans	4	4	5	5	7	7	11	13	7	6	5	2	4	3	3	3
New York City[2]	14	18	20	19	20	17	19	16	21	24	23	30	19	27	20	22
Oklahoma City	—	—	—	—	—	—	—	2	—	—	—	—	—	—	—	—
Omaha	2	2	2	2	1	1	2	2	—	—	—	2	2	3	4	5
Philadelphia	11	12	11	14	12	11	11	18	9	11	14	18	14	16	16	15
Phoenix	5	5	6	6	8	9	9	6	17	15	14	12	12	13	8	7
Portland	9	11	11	12	15	13	14	16	17	22	19	21	18	26	27	25
Sacramento	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—	8
St. Louis	6	7	9	11	11	10	10	11	7	7	16	8	8	7	9	5
Salt Lake City	—	—	—	—	—	—	—	8	—	—	—	—	—	—	—	14
San Antonio	16	15	14	13	10	10	10	10	21	14	14	14	13	13	9	9
San Diego	17	16	16	12	8	9	7	9	21	17	20	13	12	10	12	7
San Jose	8	4	6	6	5	5	6	4	7	9	8	10	10	9	12	5
Seattle	—	—	—	—	—	—	—	17	—	—	—	—	—	—	—	17
Spokane	—	—	—	—	—	—	—	9	—	—	—	—	—	—	—	17
Tucson	—	—	—	—	—	—	—	7	—	—	—	—	—	—	—	7
Washington, DC	10	11	10	9	8	9	10	10	16	19	21	13	16	11	11	10

— Data not available.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 21. Percentage[1] of Adult Booked Arrestees Who Used Methamphetamine, by Sex: 1991–98

	Males								Females							
	1991	1992	1993	1994	1995	1996	1997	1998	1991	1992	1993	1994	1995	1996	1997	1998
Albuquerque	—	—	—	—	—	—	—	3.4	—	—	—	—	—	—	—	2.4
Anchorage	—	—	—	—	—	—	—	0.0	—	—	—	—	—	—	—	0.0
Atlanta	0.2	0.1	0.4	0.1	0.4	—	0.6	0.0	0.3	0.0	0.3	0.3	0.6	—	0.7	—
Birmingham	0.1	0.0	0.0	0.2	0.1	—	0.6	0.0	0.3	0.0	1.2	1.2	0.0	—	0.5	0.0
Chicago	0.0	0.0	0.0	0.1	0.0	—	0.3	0.2	—	—	—	—	—	—	—	0.0
Cleveland	0.0	0.0	0.0	0.0	0.0	—	0.0	0.0	0.3	0.0	0.0	0.0	0.0	—	0.0	0.0
Dallas	0.6	0.9	2.0	2.0	2.2	—	2.6	3.3	1.5	2.7	3.3	3.3	3.7	—	2.8	4.0
Denver	0.8	1.0	1.2	2.1	4.1	—	5.0	5.2	1.7	1.4	2.1	2.1	3.2	—	4.6	4.6
Des Moines	—	—	—	—	—	—	—	10.2	—	—	—	—	—	—	—	24.2
Detroit	0.1	0.0	0.0	0.0	0.0	—	0.0	0.2	0.0	0.0	0.0	0.0	0.6	—	0.0	0.0
Ft. Lauderdale	0.0	0.0	0.0	0.0	0.1	—	0.1	0.0	0.0	0.0	0.2	0.2	0.0	—	0.0	0.0
Houston	0.1	0.1	0.1	0.0	0.1	—	0.0	0.2	0.9	0.0	0.2	0.2	0.9	—	0.5	0.0
Indianapolis	0.0	0.1	0.2	0.4	0.8	—	0.2	0.8	0.3	0.0	0.6	0.6	0.0	—	0.2	0.0
Laredo	—	—	—	—	—	—	—	0.0	—	—	—	—	—	—	—	0.0
Las Vegas	—	—	—	—	—	—	—	13.8	—	—	—	—	—	—	—	24.3
Los Angeles	5.4	4.8	8.2	7.7	5.8	—	4.7	8.0	6.8	8.0	9.8	9.8	11.3	—	8.9	11.8
Miami	0.0	0.0	0.0	0.0	0.0	—	0.0	0.2	—	—	—	—	—	—	—	—
Minneapolis	—	—	—	—	—	—	—	0.8	—	—	—	—	—	—	—	0.0
New Orleans	0.2	0.2	0.0	0.1	0.0	—	0.0	0.2	0.3	0.5	0.5	0.5	0.0	—	0.0	0.3
New York City[2]	0.2	0.0	0.1	0.3	0.0	—	0.0	0.0	0.0	0.0	0.0	0.0	0.2	—	0.0	0.0
Oklahoma City	—	—	—	—	—	—	—	8.0	—	—	—	—	—	—	—	—
Omaha	0.1	0.5	1.4	3.3	7.8	—	9.7	10.2	—	—	2.7	2.7	10.3	—	13.3	13.6
Philadelphia	0.5	0.5	0.4	0.1	0.4	—	0.6	0.6	0.2	0.4	0.7	0.7	1.1	—	0.0	0.3
Phoenix	4.5	5.1	15.6	25.4	22.0	—	16.4	16.4	5.6	6.9	26.0	26.0	21.7	—	25.6	22.4
Portland	7.5	5.9	11.3	16.3	18.1	—	15.9	18.1	11.5	7.3	21.4	21.4	19.7	—	20.7	22.3
Sacramento	—	—	—	—	—	—	—	24.6	—	—	—	—	—	—	—	29.2
St. Louis	0.2	0.1	0.0	0.5	0.6	—	0.4	0.3	0.0	0.0	0.0	0.0	0.3	—	2.1	2.5
Salt Lake City	—	—	—	—	—	—	—	20.3	—	—	—	—	—	—	—	31.4
San Antonio	1.3	0.8	0.6	1.0	1.1	—	1.7	2.0	1.6	1.6	0.7	0.7	2.5	—	2.4	1.7
San Diego	18.0	23.7	35.5	41.0	36.0	—	39.6	33.2	24.9	25.5	53.0	53.0	40.2	—	42.2	33.3
San Jose	6.6	5.9	15.3	19.9	16.3	—	18.4	19.7	7.1	11.3	23.3	23.3	23.6	—	24.9	21.1
Seattle	—	—	—	—	—	—	—	6.4	—	—	—	—	—	—	—	5.2
Spokane	—	—	—	—	—	—	—	15.8	—	—	—	—	—	—	—	22.0
Tucson	—	—	—	—	—	—	—	4.0	—	—	—	—	—	—	—	2.5
Washington, DC	0.1	0.0	0.1	0.1	0.1	—	0.3	0.0	0.0	0.0	0.0	0.0	0.0	—	0.0	0.5

— Data not available.

[1] Percent positive by urinalysis, January through December of each year.

[2] Data prior to the third quarter of 1998 pertain to Manhattan only.

Source: 1991–1996 data from "Drug Use Forecasting" (1991–1996); 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 22. Percentage of Juvenile Male Booked Arrestees Who Used Selected Drugs,[1] 1994–97

	Any drug use[2]					Marijuana use					Cocaine use					Opiate use					Methamphetamine use				
	1994	1995	1996	1997	1998	1994	1995	1996	1997	1998	1994	1995	1996	1997	1998	1994	1995	1996	1997	1998	1994	1995	1996	1997	1998
Birmingham	38	44	55	63	51	34	42	53	61	47	6	6	9	8	9	2	1	2	2	0	—	—	—	2.1	0.0
Cleveland	47	53	63	61	62	42	47	62	58	60	17	17	12	12	12	*	0	*	2	0	—	—	—	0.0	0.0
Denver	54	51	61	65	62	52	49	60	62	59	10	8	7	8	13	*	*	*	0	0	—	—	—	1.2	0.7
Indianapolis	30	34	44	42	50	26	33	43	39	47	8	5	6	3	11	1	*	*	1	0	—	—	—	0.2	0.0
Los Angeles	37	42	57	62	61	31	34	51	55	56	8	12	13	12	15	*	1	1	1	1	—	—	—	6.5	3.6
Phoenix	51	48	56	56	69	41	41	52	49	64	11	8	13	14	14	0	1	1	1	1	—	—	—	6.5	6.0
Portland	23	19	38	43	53	18	16	36	41	50	3	2	3	4	4	*	*	*	1	1	—	—	—	2.5	3.0
St. Louis	38	38	56	54	40	34	34	56	54	40	10	5	4	4	2	2	2	0	1	0	—	—	—	0.0	0.0
San Antonio	39	44	50	58	55	35	41	48	53	49	9	6	10	15	8	1	*	4	3	1	—	—	—	0.3	0.4
San Diego	42	53	53	63	56	33	48	48	53	49	2	4	5	4	4	1	1	1	2	1	—	—	—	17.2	12.2
San Jose	35	35	46	52	42	28	31	41	45	35	5	4	4	4	6	*	*	*	0	2	—	—	—	13.7	9.0
Tucson	—	—	—	—	51	—	—	—	—	48	—	—	—	—	5	—	—	—	—	0	—	—	—	—	0.0
Washington, DC	64	58	67	66	59	61	54	65	65	57	9	4	4	4	3	*	1	*	0	2	—	—	—	0.0	0.0

— Data not available.

* Less than one percent.

[1] Percent positive by urinalysis, January through December of each year. Percentages are rounded.

[2] "Any drug" includes cocaine, opiates, PCP, marijuana, amphetamines, methadone, methaqualone, benzodiazepines, barbiturates, and propoxyphene.

Source: 1994–1996 data from "Drug Use Forecasting" (1994–1996), 1997 and 1998 data from "Annual Report on Adult and Juvenile Arrestees," (1997 and 1998) *Arrestee Drug Abuse Monitoring Program*, National Institute of Justice.

Table 23. Substance Abuse among Probationers, State Prison Inmates, and Federal Prison Inmates

	Number	Ever Used	Used Regularly*	Used Month Prior to Offense	Used at Time of Offense
Probation (1995)[1]	2,065,896	69.4%	43.4%	31.8%	13.5%
State Prison Inmates (1977)[2]	1,059,607	83.0%	69.6%	56.5%	32.6%
Federal Prison Inmates (1997)[3]	88,018	72.9%	57.3%	44.8%	22.4%

* Regular use defined as once a week or more for at least a month

[1] Substance Abuse of Adults on Probation, 1995 (March 1998)

[2] Substance Abuse Among State and Federal Prisoners, 1997

[3] Substance Abuse Among State and Federal Prisoners, 1997 (December 1998)

Source: Bureau of Justice Statistics, Office of Justice Programs, Department of Justice. *1995 Survey of Adults on Probation and 1997 Survey on Inmates in State and Federal Correctional Facilities.*

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Table 24. Alcohol, Drug, and Mental Health (ADM) Problems Among Homeless Clients, 1996

Any Combination	Past Month (%)	Past Year (%)	Lifetime (%)
Any ADM Problem	66	74	86
Alcohol Problem	38	46	62
Drug Problem	26	38	58
Mental Health Problem	39	45	57
Specific Combinations			
Alcohol Problem Only	13	12	9
Drug Problem Only	7	7	6
Mental Health Problem Only	17	15	10
Alcohol and Drug Problems	7	10	15
Alcohol and Mental Health Problems	10	10	15
Drug and Mental Health Problems	5	7	8
Alcohol, Drug, and Mental Health Problems	8	14	30
No ADM problems	34	26	14

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

Table 25. Characteristics Perceived by Respondents to Prevent Exit from Homelessness, 1996

	Percentage*
Insufficient Income	30
Lack of a Job	24
No Suitable Housing	11
Addiction to Alcohol or Drugs	9
Other	24

*May not sum to 100% due to rounding.

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

Table 26. Substance Use Experiences by Homeless Status, 1996

	Currently Homeless (N=2938)	Formerly Homeless Clients (N=677)	Other Service Users (N=518)
When first started drinking3 or more alcoholic beverages a week			
Before age 15	36(%)	29(%)	13(%)
Between ages 15 and 17	29	28	33
When first started using illegal drugs			
Before age 15	31	28	27
Between ages 15 and 17	32	21	22

Source: Interagency Council on the Homeless. *Homelessness: Programs and the People They Serve.* U.S. Department of Housing and Urban Development, 1999.

DRUG USE CONSEQUENCES

Table 27. Lost Potential Productivity Due to Drug Abuse, 1992 and 1995* (Millions of Current Dollars)

	1992	1995
Lost earnings – premature death	$14,575	$16,247
Lost earnings – illness	$15,682	$17,481
Lost earnings – crime victims	$39,164	$43,829
Total	$69,421	$77,557

Source: National Institute on Drug Abuse and National Institute on Alcohol Abuse and Alcoholism (1998). *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992.*

Table 28. Number of Deaths and Death Rates for Drug-Induced Causes,[1] by Sex and Race: United States, 1979–97

Year	Both Sexes	Male	Female	White	All Non-White	Black[2]
		Number			Number	
1979	7,101	3,656	3,445	6,116	985	897
1980	6,900	3,771	3,129	5,814	1,086	1,006
1981	7,106	3,835	3,271	5,863	1,243	1,152
1982	7,310	4,130	3,180	5,991	1,319	1,212
1983	7,492	4,145	3,347	6,187	1,305	1,194
1984	7,892	4,640	3,252	6,309	1,583	1,480
1985	8,663	5,342	3,321	6,946	1,717	1,600
1986	9,976	6,284	3,692	7,948	2,028	1,906
1987	9,796	6,146	3,650	7,547	2,249	2,101
1988	10,917	7,004	3,913	8,409	2,508	2,395
1989	10,710	6,895	3,815	8,336	2,374	2,236
1990	9,463	5,897	3,566	7,603	1,860	1,703
1991	10,388	6,593	3,795	8,204	2,184	2,037
1992	11,703	7,766	3,937	9,360	2,343	2,148
1993	13,275	9,052	4,223	10,394	2,881	2,688
1994	13,923	9,491	4,432	10,895	3,028	2,780
1995	14,218	9,909	4,309	11,173	3,045	2,800
1996	14,843	10,093	4,750	11,903	2,940	2,682
1997	15,973	10,991	4,982	12,863	3,110	2,816
		Rate per 100,000 population			Rate per 100,000 population	
1979	3.2	3.4	3.0	3.2	3.2	3.4
1980	3.0	3.4	2.7	3.0	3.4	3.8
1981	3.1	3.4	2.8	3.0	3.8	4.2
1982	3.2	3.7	2.7	3.0	3.9	4.4
1983	3.2	3.6	2.8	3.1	3.8	4.3
1984	3.3	4.0	2.7	3.1	4.5	5.2
1985	3.6	4.6	2.7	3.4	4.8	5.6
1986	4.2	5.4	3.0	3.9	5.5	6.6
1987	4.0	5.2	2.9	3.7	6.0	7.2
1988	4.5	5.9	3.1	4.1	6.5	8.1
1989	4.3	5.7	3.0	4.0	6.0	7.4
1990	3.8	4.9	2.8	3.6	4.6	5.6
1991	4.1	5.4	2.9	3.9	5.3	6.5
1992	4.6	6.2	3.0	4.4	5.6	6.8
1993	5.1	7.2	3.2	4.8	6.7	8.4
1994	5.3	7.5	3.3	5.0	6.9	8.5
1995	5.4	7.7	3.2	5.1	6.8	8.4
1996	5.6	7.8	3.5	5.4	6.5	8.0
1997	6.0	8.4	3.6	5.8	6.7	8.3

[1]Causes of death attributable to drug-induced mortality include ICD-9 No. 292, drug psychoses; No. 304, drug dependence; Nos. 305.2–305.9, nondependent use of drugs not including alcohol and tobacco; Nos. E850–E858, accidental poisoning by drugs, medicaments, and biologicals; Nos. E950.0–E950.5, suicide by drugs, medicaments, and biologicals; No. E962.0, assault from poising by drugs and medicaments, and Nos. E980.0–E980.5, poisoning by drugs, medicaments, and biologicals, undetermined whether accidentally or purposely inflicted. Drug-induced causes exclude accidents, homicides, and other causes indirectly related to drug use. Also excluded are newborn deaths associated with mother's drug use.

[2]"Black" is a subgroup of "All Non-White."

Source: Hoyert, D.L., Kochanek, K.D., Murphy, S.L. "Deaths: Final Data for 1997." *National Vital Statistics Report*, Vol. 47, No. 19, Hyattsville, MD: National Center for Health Statistics, 1999.

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Table 29. Trends in Drug-Related Emergency Room Episodes and Selected Drug Mentions, 1988–98

	Emergency room episodes and drug mentions				
	Total drug episodes	Total drug mentions	Total cocaine mentions	Total heroin mentions	Total marijuana mentions
1988	403,578	668,153	101,578	38,063	19,962
1989	425,904	713,392	110,013	41,656	20,703
1990	371,208	635,460	80,355	33,884	15,706
1991	393,968	674,861	101,189	35,898	16,251
1992	433,493	751,731	119,843	48,003	23,997
1993	460,910	796,762	123,423	63,232	28,873
1994	518,521	900,317	142,878	64,013	40,183
1995	513,633	901,206	135,801	70,838	45,271
1996	514,347	907,561	152,433	73,846	53,789
1997	527,058	943,937	161,087	72,010	64,744
1998	542,544	982,856	172,014	77,645	76,870

Source: *Drug Abuse Warning Network*, National Institute on Drug Abuse (1988–91) and Substance Abuse and Mental Health Services Administration (1992–98).

Table 30. Estimated Number of Persons Living with AIDS[1] by Sex and Exposure Category, 1993–98

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	86,936	34,484	13,569	1,617	6,113	927	1,078	144,724	33.2%
1994	95,589	40,239	14,537	1,702	7,934	964	1,039	162,004	33.8%
1995	102,248	44,670	15,251	1,732	9,834	1,026	1,048	175,809	34.1%
1996	111,880	49,193	15,880	1,746	12,320	1,107	1,101	193,227	33.7%
1997	123,944	54,464	17,038	1,791	15,142	1,225	1,159	214,763	33.3%
1998	135,629	59,252	18,088	1,858	17,970	1,357	1,227	235,381	32.9%
Female adult/adolescent									
1993	N/A	13,771	N/A	94	11,830	780	402	26,877	51.2%
1994	N/A	16,152	N/A	111	15,174	870	411	32,718	49.4%
1995	N/A	18,258	N/A	141	18,554	930	414	38,297	47.7%
1996	N/A	20,252	N/A	173	22,610	1,032	451	44,518	45.5%
1997	N/A	22,541	N/A	215	27,045	1,149	497	51,447	43.8%
1998	N/A	24,546	N/A	247	31,465	1,285	542	58,085	42.3%

N/A Not applicable.

[1]Excludes pediatric AIDS cases (<13 years old). These numbers do not represent actual cases of persons living with AIDS. Rather, these numbers are point estimates of persons living with AIDS derived by subtracting the estimated cumulative number of deaths in persons with AIDS from the estimated cumulative number of persons with AIDS. Estimated AIDS cases are adjusted for reporting delays and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

[2]Includes receipt of blood components or tissue.

[3]Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1999; 11(No.1), Table 25.

Table 31. Estimated Number of Deaths of Persons with AIDS[1] by Sex and Exposure Category, 1993–98

	Exposure Category								
	Men who have sex with men (MSM)	Injecting drug use (IDU)	MSM and IDU	Hemophilia/coagulation disorder	Heterosexual contact	Receipt of blood transfusion[2]	Risk not reported or identified	Total	Percent drug-related[3]
Male adult/adolescent									
1993	23,674	9,216	3,117	352	1,565	314	160	38,398	32.1%
1994	24,973	10,281	3,426	346	1,967	301	142	41,435	33.1%
1995	24,356	10,669	3,332	326	2,323	259	99	41,365	33.8%
1996	16,436	8,417	2,504	239	2,049	216	60	29,920	36.5%
1997	8,401	5,246	1,365	135	1,420	113	47	16,727	39.5%
1998	6,467	4,241	1,142	95	1,190	80	27	13,242	40.7%
Female adult/adolescent									
1993	N/A	3,109	N/A	17	2,624	236	69	6,054	51.4%
1994	N/A	3,675	N/A	26	3,447	225	55	7,429	49.5%
1995	N/A	3,762	N/A	29	3,919	226	57	7,993	47.1%
1996	N/A	3,244	N/A	29	3,398	171	34	6,875	47.2%
1997	N/A	2,106	N/A	21	2,258	95	20	4,500	46.8%
1998	N/A	1,778	N/A	15	1,924	74	16	3,807	46.7%

N/A Not applicable.

[1]Excludes pediatric AIDS cases (<13 years old). These numbers do not represent actual deaths of persons with AIDS. Rather, these numbers are point estimates adjusted for delays in the reporting of deaths and for redistribution of cases initially reported with no identified risk, but not for incomplete reporting. Annual estimates are through the most recent year for which reliable estimates are available.

[2]Includes receipt of blood components or tissue.

[3]Proportion includes injection drug users and MSM who are injection drug users.

Source: Centers for Disease Control and Prevention. *HIV/AIDS Surveillance Report*, 1999; 11(No.1), Table 28.

Table 32. Reported Tuberculosis Cases and Percent of Cases in Injecting and Noninjecting Drug Users 1996-98

	1996	1997	1998
Total Tuberculosis Cases	21,337	19,851	18,361
Cases with information on injecting drug user (number)	18,467	17,678	16,849
Cases with information on injecting drug user (percent)	86.5%	89.1%	91.8%
Percent of cases in injecting drug users[1]	***3.8%***	***3.3%***	***2.9%***
Cases with information on noninjecting drug user (number)	18,265	17,555	16,730
Cases with information on noninjecting drug user (percent)	85.6%	88.4%	91.1%
Percent of cases in noninjecting drug users[1]	***7.7%***	***7.8%***	***7.7%***

[1]Injecting drug use within past 12 months. Percentages shown only for reporting areas with information reported for >=75% of cases.

Source: Centers for Disease Control and Prevention. *Reported Tuberculosis in the United States, 1996, 1997, and 1998.*

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Table 33. Reported Hepatitis Cases, 1995-97

	1995	1996	1997
	Number of Reported Cases		
Hepatitis A	31,582	31,032	30,021
Hepatitis B	10,805	10,637	10,416
Hepatitis C	4,576	3,716	3,816
	Reported Cases per 100,000 Population		
Hepatitis A	12.13	11.70	11.22
Hepatitis B	4.19	4.01	3.90
Hepatitis C	1.78	1.41	1.43

Source: Centers for Disease Control and Prevention. Summary of Notifiable Diseases, United States 1997. *Morbidity and Mortality Weekly Report* 46(54).1998.

Table 34. Total Crime, Violent Crime, and Property Crime, 1989–98

Year	Total crime index[1]	Total crime rate[2]	Violent crime index[1]	Violent crime rate[2]	Total murder victims[1]	Murders related to narcotic drug laws	Property crime[1]	Property crime rate[2]
1989	14,251,400	5,741.0	1,646,040	663.1	21,500	1,402	12,605,400	5,077.9
1990	14,475,613	5,820.3	1,820,127	731.8	23,438	1,367	12,655,486	5,088.5
1991	14,872,883	5,897.8	1,911,767	758.1	24,703	1,353	12,961,116	5,139.7
1992	14,438,191	5,660.2	1,932,274	757.5	23,760	1,302	12,505,917	4,902.7
1993	14,144,794	5,484.4	1,926,017	746.8	24,526	1,295	12,218,777	4,737.6
1994	13,989,543	5,373.5	1,857,670	713.6	23,326	1,239	12,131,873	4,660.0
1995	13,862,727	5275.9	1,798,792	684.6	21,606	1,031	12,063,935	4,591.3
1996	13,493,863	5,086.6	1,688,540	636.5	19,645	843	11,805,323	4,450.1
1997	13,194.751	4,930.0	1,636,096	611.3	18,209	786	11,5558,475	4,318.7
1998	12,475,634	4,615.5	1,531,044	566.4	16,914	679	10,944,590	4,049.1

[1] Number of offenses reported to law-enforcement agencies.

[2] Rates per 100,000 inhabitants.

Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-99).

Table 35. Total Estimated Arrests and Drug Arrests, 1989–98

Year	Total arrests	Arrests for all drug abuse violations[1]		Distribution of arrests for drug abuse violations[2]					
				Heroin/cocaine[3]		Marijuana		Other drugs	
		Number	Percent	Sale[4]	Possession	Sale[4]	Possession	Sale[4]	Possession
1989	14,340,900	1,361,700	9.4	19.1	34.7	6.2	23.1	7.0	9.8
1990	14,195,100	1,089,500	7 6	21.0	33.3	6.1	23.9	4.5	11.2
1991	14,211,900	1,010,000	7.1	22.5	32.8	6.1	22.4	4.8	11.5
1992	14,075,100	1,066,400	7.5	20.6	32.4	6.6	25.5	4.6	10.4
1993	14,036,300	1,126,300	8.0	19.2	31.1	6.2	27.6	4.3	11.6
1994	14,648,700	1,351,400	9.2	16.8	30.3	5.8	29.8	4.1	13.2
1995	15,119,800	1,476,100	9.7	14.7	27.8	5.8	34.1	4.4	13.3
1996	15,168,100	1,506,200	9.9	14.2	25.6	6.3	36.3	4.3	13.3
1997	15,284,300	1,583,600	10.3	10.3	25.4	5.6	38.3	4.7	15.8
1998	14,528,300	1,559,100	10.7	11.0	25.6	5.4	38.4	4.8	14.8

[1]Arrest totals are based on all reporting agencies and estimates for unreported areas from Section IV table entitled "Total Estimated Arrests, Unites States."

[2]Because of rounding, percentages across may not add up to 100%.

[3]Includes heroin or cocaine and their derivatives.

[4] Includes sale/manufacture of drugs.

Source: *Crime in the United States: Uniform Crime Reports*, U.S. Department of Justice, Federal Bureau of Investigation (1990-99).

Table 36. Adults in Custody of State or Federal Prisons or Local Jails, 1989–98

	State prisons	Federal prisons	Total State and Federal prisons	Percent of prisoners who are drug offenders		Local jails
				Federal	State	
1989	629,995	53,387	683,382	49.9	19.1	395,553
1990	684,544	58,838	743,382	53.5	21.7	405,320
1991	728,605	63,930	792,535	55.9	21.3	426,479
1992	778,495	72,071	850,566	58.9	22.1	444,584
1993	828,566	80,815	909,381	59.2	22.1	459,804
1994	904,647	85,500	990,147	60.5	22.4	486,474
1995	989,004	89,538	1,078,542	59.9	22.7	507,044
1996	1,032,440	95,088	1,127,528	60.0	22.7	518,492
1997	1,059,588	99,175	1,176922	62.6	20.7	567,079
1998*	1,178,978	123,041	1,232,900	—	20.6	592,462

*The 1998 prison custody count was estimated and rounded to nearest 100.

— Data not available.

Sources: Bureau of Justice Statistics Bulletin, *Prisoners in 1998* (August 1999), *Prisoners in 1997* (August 1998). *Correctional Populations in the United States*, 1995, 1994; 1993; 1992; 1991; 1990; 1989. *Jails and Jail Inmates*, 1993–94. *Jail Inmates*, 1992; 1990. Data for 1997 percentages of drug offenders are estimated from Bureau of Justice Statistics Special Report, *Substance Abuse and Treatment, State and Federal Prisoners, 1997*. (January 1999).

DRUG TREATMENT

Table 37. One-Day Census of Clients in Treatment, by Facility Service Orientation, 1980–98

	Free standing substance abuse treatment[1]	Mental health services[2]	Physical health services[3]	Other community services and settings[4]	Correctional settings and services[5]	Total
1980	250,378	106,157	57,365	62,860	12,143	488,903
1982	216,123	107,653	60,197	69,456	9,983	463,412
1984	346,980	139,411	107,167	63,426	13,303	670,279
1987	368,775	99,184	79,889	56,841	9,434	614,123
1989	455,970	120,063	81,063	73,663	14,196	734,955
1990	449,212	137,690	73,362	81,493	26,082	767,829
1991	493,967	140,895	71,004	66,683	39,270	811,819
1992	594,269	161,949	103,591	54,413	30,658	944,880
1993	565,293	150,519	94,368	95,682	37,368	944,208
1995	459,525	255,282	170,989	31,675	91,656	1,009,127
1996	514,265	189,853	120,015	38,382	77,626	940,14
1997	479,184	225,777	125,061	39,467	59,597	929,086
1998*	581,119	262,536	145,901	39,316	109,130	1,138,002

* Preliminary data

[1] Free-standing substance abuse treatment includes facilities that provide no medical or mental health services other than substance abuse treatment.

[2] Mental health settings and services include psychiatric hospitals and community mental health centers or other mental health facilities that provide a range of mental health services in addition to substance abuse treatment.

[3] Physical health settings and services include hospitals and community health centers that provide medical services in addition to substance abuse treatment. These facilities may also provide mental health services.

[4] Community settings and services are community or religious agencies or organizations that provide social services in addition to substance abuse treatment. Schools are included in this category.

[5] Criminal justice system includes jails, prisons, juvenile detention facilities, TASC pretrial diversion, court referral, probation, parole, community corrections, and drug courts.

Note: Changes in data collection methods include: 1) Prior to 1992, no attempt was made to adjust for survey non-response. Beginning in 1992, survey non-respondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients. 2) The number of possible responses to the 'Facility service orientation' question increased from 7 in 1980 to 16 in 1998. Beginning in 1995, facilities were permitted to select more than setting. While this table summarizes facility service orientation in broad categories, some misclassification is possible. 3) Prior to 1995, facilities providing programs for DUI/DWI offenders could not be distinguished. In 1995 and 1996, these facilities were identified and classified in the above table as 'Correctional settings'. 2) In 1997 only, facilities providing programs for DUI/DWI offenders did not complete the full survey, and did not provide client counts.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Drug and Alcoholism Treatment Unit Survey (NDATUS) 1980-1993*; Uniform Facility Data Set Survey (UFDS), 1995-98.

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Table 38. One-Day Census of Clients in Alcohol and/or Drug Abuse Treatment, by Age Group and Sex, 1987–98

Year	Age Group							Sex		
	Under 18 years	18-24 years	24-34 years	35-44 years	45-64 years	65 years and over	Total	Male	Female	Total
1987	63,245	123,384	199,362	141,612	79,151	6,949	613,703	443,931	169,772	613,703
1989	75,204	144,457	244,156	174,360	89,049	7,729	734,955	517,581	217,374	734,955
1990	49,107	143,340	269,040	200,108	98,463	7,771	767,829	553,968	213,861	767,829
1991	48,045	147,617	286,066	216,778	105,107	8,206	811,819	588,295	223,524	811,819
1992	51,223	155,936	332,330	267,162	129,275	8,954	944,880	671,997	272,883	944,880
1993	59,818	153,040	325,330	264,906	131,352	9,762	944,208	663,968	280,240	944,208
1995	70,050	143,750	314,003	299,620	167,757	13,947	1,009,127	707,252	301,875	1,009,127
1996	76,687	122,739	283,673	295,780	145,819	15,443	940,141	640,369	299,772	940,141
1997	81,456	160,376	270,286	264,549	135,758	16,661	929,086	632,113	296,973	929,086
1998*	102,340	201,302	312,030	325,326	179,205	17,799	1,138,002	779,873	358,129	1,138,002

* Preliminary data

Note: Changes in data collection methods are reflected in the table: 1) Prior to 1992, no attempt was made to adjust for survey non-response. Beginning in 1992, survey non-respondents were contacted to obtain a minimum data set. This is reflected in larger and more consistent numbers of clients. 2) In 1997 only, facilities providing programs for DUI/DWI offenders did not complete the full survey, and did not provide client counts.

Source: Substance Abuse and Mental Health Services Administration, Office of Applied Studies. *National Drug and Alcoholism Treatment Unit Survey (NDATUS) 1987-1993*; Uniform Facility Data Set Survey (UFDS), 1995-98.

Table 39. Estimates of Number of Persons Needing and Receiving Treatment for Drug Abuse Problems, 1991–98 (Thousands)

	Total drug abuse treatment need	Level 1*	Level 2*				
		Needs treatment	Needs treatment	Clients treated	Percent treated	Percent not treated	Treatment gap
1991	8,991	3,843	5,148	1,649	32	68	3,499
1992	8,599	3,881	4,718	1,814	38	62	2,904
1993	8,067	3,326	4,741	1,848	39	61	2,893
1994	8,329	3,719	4,610	1,984	43	57	2,626
1995	8,906	4,260	4,646	2,121	46	54	2,525
1996	9,383	4,080	5,303	1,973	37	63	3,330
1997	9,474	3,748	5,726	2,137	37	63	3,589
1998	8,993	3,962	5,031	2,137	43	57	2,894

* The need for treatment varies according to the severity of the problem. To reflect these differences, HHS divided those needing treatment into two categories, termed Level 1 and Level 2, based on intensity of drug use, symptoms, and consequences. The more severe category of need is Level 2, meaning the severity of symptoms make these users prime candidates for treatment. Level 2 users correspond to chronic, hardcore users discussed on the National Drug Control Strategy.

Note: Estimates for 1991–98 are ratio-adjusted to partially account for underestimation due to underreporting and undercoverage in the NHSDA. Estimates for 1991–93 are also adjusted for trend consistency to account for the change in the NHSDA questionnaire in 1994. Adjustment factors for trend consistency were 1.19020 for total treatment need and 1.21125 for Level 2 treatment need.

Due to improvements in coverage in the Uniform Facility Data Set (UFDS) in 1998, UFDS counts of clients in treatment are not comparable to earlier counts. Therefore, the 1997 estimate of number treated was used to estimate treatment gap in 1998. This methodology is currently being reviewed by an interagency working group. Treatment need is to be defined based on estimating those diagnosed with drug abuse or dependence according to DSM-IV criteria.

Source: Office of Applied Studies, SAMHSA. Unpublished data from the *National Household Survey on Drug Abuse* and *Uniform Facility Data Set* (1991–1998).

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Table 40. Number of clients in treatment per 100,000 population aged 12 and over by substance abuse problem, according to State or jurisdiction:[1] October 1, 1997

State or Jurisdiction[2]	Substance abuse problem			
	Total	Both alcohol and drug abuse	Drug abuse only	Alcohol abuse only
Clients in treatment	916,637	376,482	299,593	240,562
Alaska	10,664	2,385	5,808	2,471
Alabama	5,261	2,101	894	2,266
Arizona	12,307	4,297	4,612	3,398
Arkansas	4,129	1,652	1,588	889
California	88,876	36,421	39,646	12,809
Colorado	13,530	4,388	4,297	4,845
Connecticut	15,592	5,949	7,199	2,444
Delaware	3,567	2,256	624	687
District of Columbia	8,201	2,722	4,033	1,446
Florida	41,663	19,358	13,908	8,397
Georgia	16,118	7,299	4,883	3,936
Hawaii	2,177	893	784	500
Idaho	2,464	1,717	360	387
Illinois	39,040	17,967	10,839	10,234
Indiana	18,458	7,597	4,334	6,527
Iowa	5,373	2,580	870	1,923
Kansas	8,288	3,906	1,637	2,745
Kentucky	12,119	4,093	3,365	4,661
Louisiana	12,185	6,273	3,595	2,317
Maine	8,188	3,948	1,496	2,744
Maryland	23,794	10,088	8,868	4,838
Massachusetts	33,219	13,984	10,235	9,000
Michigan	49,788	18,123	14,135	17,530
Minnesota	7,593	3,621	1,275	2,697
Mississippi	5,334	2,515	1,391	1,428
Missouri	11,090	5,789	2,740	2,561
Montana	2,298	1,135	482	681
Nebraska	4,197	2,140	444	1,613
Nevada	5,279	1,697	2,158	1,424
New Hampshire	2,507	1,028	465	1,014
New Jersey	20,594	9,147	7,928	3,519
New Mexico	6,452	2,469	1,132	2,851
New York	127,272	35,175	64,260	27,837
North Carolina	17,379	8,358	3,427	5,594
North Dakota	2,086	856	242	988
Ohio	40,401	20,864	7,950	11,587
Oklahoma	7,572	2,511	2,415	2,646
Oregon	22,627	10,731	5,154	6,742
Pennsylvania	36,382	17,957	10,231	8,194
Rhode Island	5,084	1,874	1,914	1,296
South Carolina	10,862	3,943	2,513	4,406
South Dakota	1,880	739	229	912
Tennessee	13,166	6,113	4,069	2,984
Texas	40,693	14,860	14,346	11,487
Utah	13,621	5,771	3,709	4,141
Vermont	1,638	721	215	702
Virginia	21,039	10,839	4,810	5,390
Washington	31,260	17,295	4,392	9,573
West Virginia	4,704	1,159	748	2,797
Wisconsin	16,535	6,333	2,659	7,543
Wyoming	2,091	845	285	961

— Data not available.

[1] Excludes jurisdictions outside the United States and the District of Columbia.

[2] Facilities operated by Federal agencies are included in the States in which the facilities are located.

Source: *Uniform Facility Data Set* (UFDS). 1997. Substance Abuse and Mental Health Services Administration (1999).

DRUG AVAILABILITY

Table 41. Trends in Cocaine Supply, 1989–98 (Metric Tons)

Year	Cocaine HCl available for export from producing countries[1]	Cocaine destined for the United States	Cocaine shipped to the United States	Cocaine available for consumption in the United States	Retail value of cocaine in the United States (1998 dollars, billions)[2]
1989	709–842	603–716	547–660	432–545	$70.8
1990	714–851	595–709	509–624	413–528	$61.3
1991	777–931	635–760	539–664	412–532	$55.0
1992	834–972	667–778	583–694	437–555	$49.4
1993	581–692	455–542	375–462	364–463	$45.9
1994	558–670	428–513	371–456	258–345	$42.4
1995	616–738	462–553	421–513	287–376	$43.0
1996*	601	567	486	347	$41.3
1997*	569	524	398	281	$41.8
1998*	616	553	454	301	$39.0

* Estimates derived from the implementation of the Office of National Drug Control Policy's *Sequential Transition and Reduction* (STAR) Model, December 1999.

[1] Estimates of cocaine hydrochloride come from a computer model of cocaine production. The range is based on the error band reported by the Department of State for the area under cultivation.

[2] Estimates are a two-year moving average of years T and T-1. The estimate for 1989 is for year 1989 alone.

Source: 1989 to 1998 data from Office of National Drug Control Policy, 1999. *What America's Users Spend on Illegal Drugs, 1988–1998*. Cocaine HCl data for 1996 to 1998 are from ONDCP's *Sequential Transition and Reduction* (STAR) Model, December 1999.

Table 42. Average Price and Purity of Cocaine and Heroin in the United States, 1981–98

Year	Cocaine				Heroin			
	Purchases of 1 gram or less[1]		Purchases of 10–100 pure grams[2]		Purchases of 0.1 gram or less[1]		Purchases of 1–10 pure grams[2]	
	Price per pure gram	Purity	Price per pure gram	Purity	Price per pure gram	Purity	Price per pure gram	Purity
1981	$378.70	40.02	$191.35	59.59	$3,114.80	4.69	$1,194.05	19.10
1982	392.97	39.58	175.56	59.72	3,097.95	5.79	1,185.42	32.84
1983	360.21	42.06	166.86	67.82	3,319.86	7.66	1,313.20	30.09
1984	335.49	45.98	145.51	74.88	3,135.70	9.27	1,290.00	35.95
1985	303.31	40.96	137.80	68.52	2,930.90	9.91	1,161.00	42.83
1986	291.09	52.51	122.73	74.48	3,263.59	11.13	1,131.95	36.61
1987	268.74	65.88	104.85	81.57	2,908.00	14.00	1,120.88	35.82
1988	218.33	75.99	78.84	83.53	2,874.19	19.22	947.32	39.48
1989	208.87	78.82	64.89	80.61	2,358.20	19.82	784.88	43.12
1990	246.03	69.86	66.05	67.68	2,615.49	16.85	833.68	31.95
1991	213.57	78.51	68.08	73.42	2,704.10	18.47	867.25	30.61
1992	208.54	76.87	56.93	77.87	2,539.44	22.81	678.30	37.66
1993	187.76	73.49	57.54	72.46	2,341.72	25.89	517.75	49.24
1994	171.54	73.74	54.08	73.31	2,332.28	25.82	436.59	48.31
1995	173.25	68.38	49.79	73.04	2,285.81	26.25	377.03	51.17
1996	159.05	72.50	49.45	68.44	2,175.88	23.95	373.30	45.21
1997	178.97	64.72	45.58	67.05	2,114.97	25.24	327.88	45.38
1998[3]	169.25	71.23	44.51	66.79	1798.80	24.49	317.97	51.33

[1] Quantities purchased at the "retail" level.
[2] Quantities purchased at the "dealer" level.
[3] 1998 data are preliminary, based on first 2 quarters of data.

Source: *System To Retrieve Information From Drug Evidence* (STRIDE), Drug Enforcement Administration, 1981–97.

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Table 43. Federalwide Cocaine, Heroin, Methamphetamine, and Cannabis Seizures, 1989–99 (Kilograms)

Year	Cocaine	Heroin	Metham-phetamine	Cannabis	
				Marijuana	Hashish
1989	114,903	1,311	—	393,276	23,043
1990	96,085	687	—	233,478	7,683
1991	128,247	1,448	—	224,603	79,110
1992	120,175	1,251	—	344,899	111
1993	121,215	1,502	7	409,922	11,396
1994	129,378	1,285	178	474,856	561
1995	111,031	1,543	369	627,776	14,470
1996	128,555	1,362	136	638,863	37,851
1997	101,495	1,624	1,099	698,799	756
1998	118,398	1,475	2,559	825,303	240
1999*	132,318	1,094	2,641	1,175,373	761

*Figures are preliminary and subject to updating.

Source: *Federalwide Drug Seizure System*, Drug Enforcement Administration, 1989–1998.

Table 44. Eradicated Domestic Cannabis by Plant Type, 1982–98 (Number of Plants in Thousands)

	Cultivated Plants Outdoors[1]	Ditchweed	Indoor Plants	Total Plants Eradicated
1982	—	—	—	2,590
1983	—	—	—	3,794
1984	3,803	9,178	—	12,981
1985	3,961	35,270	—	39,231
1986	4,673	125,013	—	129,686
1987	7,433	105,842	—	113,275
1988	5,344	101,932	—	107,329
1989	5,636	124,289	—	129,925
1990	7,329	118,548	—	125,877
1991	5,257	133,786	283	139,326
1992	7,490	264,207	349	272,046
1993	4,049	387,942	290	392,281
1994	4,032	504,414	220	508,665
1995	3,054	370,275	243	373,572
1996	2,843	419,662	217	422,723
1997	3,827	237,140	224	241,193
1998	2,283	132,407	233	134,924

— Data not available.

Note: Federal data only.

[1] May include tended ditchweed.

Source: Drug Enforcement Administration, 1982-1998.

Table 45. Methamphetamine Lab Seizures, by State: 1995–99

State	1995	1996	1997	1998	1999
Alaska	0	1	0	0	10
Alabama	2	5	4	1	26
Arizona	16	83	129	222	364
Arkansas	19	74	164	148	130
California	108	155	178	118	164
Colorado	13	17	26	51	85
Connecticut	0	0	0	0	0
Delaware	1	0	1	0	0
District of Columbia	0	0	1	0	0
Florida	3	0	1	6	13
Georgia	3	4	10	3	21
Hawaii	0	0	3	0	2
Idaho	1	3	3	4	1
Illinois	0	5	14	45	67
Indiana	0	1	4	3	3
Iowa	4	10	22	19	16
Kansas	16	43	43	29	44
Kentucky	1	3	1	8	6
Louisiana	1	1	1	3	6
Maine	0	0	0	1	0
Maryland	0	0	0	0	1
Massachusetts	0	0	0	3	0
Michigan	3	2	4	3	7
Minnesota	10	14	14	21	20
Mississippi	0	1	0	5	9
Missouri	37	235	396	315	195
Montana	1	1	2	1	16
Nebraska	1	1	1	7	7
Nevada	23	37	19	15	20
New Hampshire	0	0	0	1	0
New Jersey	0	1	3	0	0
New Mexico	4	7	20	26	44
New York	0	0	0	0	1
North Carolina	0	0	2	1	4
North Dakota	1	1	1	0	6
Ohio	0	1	7	6	14
Oklahoma	8	71	106	102	200
Oregon	2	8	10	25	10
Pennsylvania	2	12	6	5	1
Rhode Island	0	0	0	0	0
South Carolina	0	0	0	0	0
South Dakota	1	1	2	0	1
Tennessee	2	2	22	50	60
Texas	10	12	24	31	101
Utah	29	63	112	91	204
Vermont	0	0	0	0	0
Virginia	0	0	2	1	8
Washington	2	1	4	8	23
West Virginia	0	0	0	1	4
Wisconsin	2	2	0	0	0
Wyoming	1	1	0	8	4
Total	327	879	1,362	1,387	1,919

Note: Federal data only.

Source: Drug Enforcement Administration (1995–1999).

Table 46. Estimated Worldwide Potential Net Production, 1988–98 (Metric Tons)

Country	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998
Opium											
Afghanistan[1]	750	585	415	570	640	685	950	1,250	1,230	1,265	1,350
India	—	—	—	—	—	—	90	77	47	30	—
Iran[2]	—	—	—	—	—	—	—	—	—	—	—
Pakistan	205	130	165	180	175	140	160	155	75	85	65
Total Southwest Asia	**955**	**715**	**580**	**750**	**815**	**825**	**1,200**	**1,482**	**1,352**	**1,380**	**1,415**
Burma	1,280	2,430	2,255	2,350	2,280	2,575	2,030	2,340	2,560	2,365	1,750
China	—	—	—	—	—	—	25	19	—	—	—
Laos	255	380	275	265	230	180	85	180	200	210	140
Thailand	25	50	40	35	24	42	17	25	30	25	16
Total Southeast Asia	**1,560**	**2,860**	**2,570**	**2,650**	**2,534**	**2,797**	**2,157**	**2,564**	**2,790**	**2,600**	**1,906**
Colombia	—	—	—	—	—	—	—	65	63	66	61
Lebanon[3]	—	45	32	34	—	4	—	1	1	—	—
Guatemala	8	12	13	11	—	—	—	—	—	—	—
Mexico	67	66	62	41	40	49	60	53	54	46	60
Vietnam	—	—	—	—	—	—	—	—	25	45	20
Total Above	**75**	**123**	**107**	**86**	**40**	**53**	**60**	**119**	**143**	**157**	**141**
Total Opium	**2,590**	**3,698**	**3,257**	**3,486**	**3,389**	**3,675**	**3,417**	**4,165**	**4,285**	**4,137**	**3,462**
Coca Leaf											
Bolivia	78,400	77,600	77,000	78,000	80,300	84,400	89,800	85,000	75,100	70,100	52,900
Colombia	27,200	33,900	32,100	30,000	29,600	31,700	35,800	40,800	53,800	63,600	81,400
Peru	187,700	186,300	196,900	222,700	155,500	155,500	165,300	183,600	174,700	130,200	95,600
Ecuador	400	270	170	40	100	100	—	—	—	—	—
Total Coca Leaf	**293,700**	**298,070**	**306,170**	**330,740**	**265,500**	**271,700**	**290,900**	**309,400**	**303,600**	**263,900**	**229,900**
Cannabis											
Mexico	5,655	30,200	19,715	7,775	7,795	6,280	5,540	3,650	3,400	2,500	2,300
Colombia	7,775	2,800	1,500	1,650	1,650	4,125	4,138	4,133	4,133	4,133	4,000
Jamaica	405	190	825	641	263	502	208	206	356	214	—
Belize	120	65	60	49	0	0	0	0	0	0	0
Other	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500	3,500
Total Cannabis	**17,445**	**36,775**	**25,600**	**13,615**	**13,208**	**14,407**	**13,386**	**11,489**	**11,389**	**10,347**	**9,800**

— Data not available.

[1] The U.S. Drug Enforcement Administration believes, based upon foreign reporting and human sources, that opium production in Afghanistan may have exceeded 900 metric tons in 1992 and 1993.

[2] While there is no solid information on Iranian opium production, the U.S. Government estimates that Iran potentially may produce between 35 and 75 metric tons of opium gum annually.

[3] There was no information for 1992 production. For 1994, a vigorous eradication campaign reduced potential production to insignificant levels.

Source: *International Narcotics Control Strategy Report (1988–1998)*, U.S. Department of State.

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Table 47. Domestic Drug Consumption, Calendar Years 1996-98 (Metric Tons)

Year	Cocaine	Heroin	Marijuana	Methamphetamine
1996	347	12.4	876	11.3
1997	281	13.1	962	10.7
1998	301	12.5	954	8.9

Source: Office of National Drug Control Policy. 1999. *What America's Users Spend on Illegal Drugs, 1988–1998.*

Table 48. Amount of Drugs Entering the U.S., Calendar Years 1996-98 (Metric Tons)

Year	Cocaine[1]	Heroin[2]
1996	402	13.8
1997	311	14.7
1998	357	14.0

[1]Office of National Drug Control Policy (1999) "Estimating Cocaine Flow: The Sequential Transition and Reduction (STAR) Model, 1996-98."

[2]Office of National Drug Control Policy (1999) "Estimating Heroin Availability."

Table 49. Amount of Coca Leaf Cultivated and Eradicated, Calendar Years 1987-98 (Hectares)

Year	CULTIVATED			ERADICATED		
	BOLIVIA	COLOMBIA	PERU	BOLIVIA	COLOMBIA	PERU
1987	41,400	22,960	109,155	1,040	460	355
1988	50,400	34,230	115,530	1,475	230	5,130
1989	55,400	43,400	121,685	2,500	640	1,285
1990	58,400	41,000	121,300	8,100	900	0
1991	53,386	38,472	120,800	5,486	972	0
1992	50,649	38,059	129,100	5,149	959	0
1993	49,600	40,493	108,800	2,400	793	0
1994	49,200	49,610	108,600	1,100	4,910	0
1995	54,093	59,650	115,300	5,493	8,750	0
1996	55,612	72,800	95,659	7,512	5,600	1,259
1997	52,800	98,500	72,262	7,000	19,000	3,462
1998	49,600	115,450	58,825	11,621	13,650	7,825

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 50. Amount of Opium Poppy Cultivated and Eradicated, Calendar Years 1990-98 (Hectares)

Year	Afganistan	Pakistan	Burma	Laos	Thailand	Colombia	Guatemala	Mexico
				CULTIVATED				
1990	12,370	8,405	150,100	30,580	3,435	—	1,930	10,100
1991	17,190	8,645	160,000	29,625	3,000	2,316	1,721	10,130
1992	19,470	9,147	153,700	25,610	2,050	32,858	1,200	10,170
1993	21,080	7,136	146,600	26,040	2,880	29,821	864	11,780
1994	29,180	7,733	154,070	18,520	2,110	23,906	200	12,415
1995	38,740	6,950	154,070	19,650	1,750	10,300	125	13,500
1996	37,950	4,267	163,100	25,250	2,170	12,328	12	13,000
1997	39,150	4,754	155,150	28,150	1,650	13,572	10	12,000
1998	41,720	5,224	130,300	26,100	1,350	—	15	15,000
				ERADICATED				
1990	—	185	—	0	720	—	1,085	4,650
1991	—	440	1,012	0	1,200	1,156	576	6,545
1992	—	977	1,215	0	1,580	12,858	470	6,860
1993	—	856	604	0	0	9,821	426	7,820
1994	—	463	3,345	0	0	3,906	150	6,620
1995	—	0	0	0	580	3,760	86	8,450
1996	—	867	0	0	880	6,028	12	7,900
1997	—	654	0	0	1,050	6,972	3	8,000
1998	—	2,194	0	—	715	—	12	9,500

— Data not available.

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 51. Amount of Marijuana Cultivated and Eradicated, Calendar Years 1990-98 (Hectares)

Year	CULTIVATED			ERADICATED		
	Mexico	Jamaica	Colombia	Mexico	Jamaica	Colombia
1990	4,250	2,250	2,000	6,750	1,030	500
1991	3,783	1,783	2,000	10,795	833	0
1992	3,249	1,200	2,049	12,100	811	49
1993	6,250	1,200	5,050	9,970	456	50
1994	6,000	1,000	5,000	8,495	692	14
1995	6,000	1,000	5,000	11,750	695	20
1996	6,000	1,000	5,000	12,200	473	—
1997	6,060	1,060	5,000	10,500	743	—
1998	5,000	—	5,000	9,500	692	—

— Data not available.

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 52. Amount of Cocaine Seized, Calendar Years 1990-98 (Metric Tons)

Year	South America	Caribbean	Central America	Mexico
1990	71	7	21	49
1991	112	7	28	50
1992	69	8	24	39
1993	65	3	25	46
1994	102	3	15	22
1995	91	5	10	22
1996	94	2	18	24
1997	95	4	30	35
1998	134	7	35	23

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 53. Amount of Heroin Seized by Foreign Countries, Calendar Years 1990-98 (Kilograms)

Year	Pakistan		Thailand		China		Laos		Colombia	
	heroin	opium	heroin	opium	heroin	opium	heroin	opium	heroin	opium
1990	6,400	8,200	1,100	800	1,445	720	40	575	0	0
1991	5,700	5,900	1,500	1,500	2,621	2,327	15	165	0	0
1992	2,900	3,400	992	600	4,489	2,660	2	281	50	430
1993	3,900	4,400	2,100	2,200	4,459	3,354	1	54	261	261
1994	6,200	14,360	1,100	600	3,881	1,737	62	54	181	128
1995	18,040	215,520	690	900	2,376	1,110	43	194	419	78
1996	4,050	8,080	390	600	3,500	1,400	16	216	183	36
1997	5,070	8,540	170	700	5,470	1,600	72	200	261	120
1998	2,360	3,650	230	1,500	0	0	80	442	317	100

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 54. Amount of Marijuana Seized by Foreign Countries, Calendar Years 1990-98 (Metric Tons)

Year	Mexico	Jamaica	Colombia	Pakistan	Thailand	Other
1990	408	29	664	241	130	10.12
1991	255	43	329	237	54	17.38
1992	405	35	206	188	87	70.92
1993	495	75	549	189	98	130.1
1994	528	46	200	178	71	32.33
1995	780	37.2	166	544	46	30.55
1996	1015	5299	235	202	44	63.92
1997	1038	24	136	100	12	85.11
1998	1062	36	69	100	5.1	34.69

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Table 55. Number of Drug Labs Destroyed, Calendar Years 1990-98

Year	Bolivia		Brazil	Colombia		Ecuador	Peru	Mexico	Thailand		Pakistan
	Coca base	Cocaine HCl	Cocaine HCl	Cocaine & base	Morphine & Heroin	Cocaine HCl	Coca base	Not specified	Heroin labs	Meth labs	Not specified
1990	1446	33	3	269	—	1	151	13	2	—	—
1991	1461	34	3	239	5	4	89	9	5	—	18
1992	1393	17	0	224	7	0	88	4	0	—	11
1993	1300	10	5	401	10	0	38	5	2	—	13
1994	1891	32	0	560	9	0	21	9	0	—	18
1995	2226	18	0	396	11	0	21	19	1	—	15
1996	2033	7	0	861	9	1	14	19	2	1	10
1997	1022	1	0	213	9	0	18	8	0	0	4
1998	1205	1	0	311	10	2		7	0	15	0

— Data not available.

Source: *International Narcotics Control Strategy Report*, March 1999. U.S. Department of State.

Glossary: Abbreviations and Acronyms

ACF – Administration for Children and Families.

ACSI – Americas Counter-Smuggling Initiative.

ADAM – Arrestee Drug Abuse Monitoring System, formerly known as the Drug Use Forecasting (DUF) program.

AIDS – Acquired Immune Deficiency Syndrome.

ASEAN – Association of Southeast Asian Nations.

ATF – Bureau of Alcohol, Tobacco and Firearms.

ATS – Amphetamine-Type Stimulants.

BASC – Business Anti-Smuggling Coalition, a program of the U.S. Customs Service.

BCI – Border Coordination Initiative.

BJA – Bureau of Justice Assistance, part of the U.S. Department of Justice.

BJS – Bureau of Justice Statistics, part of the U.S. Department of Justice.

BOP – Bureau of Prisons, part of the U.S. Department of Justice.

BTC – Breaking The Cycle.

CADCA – Community Anti-Drug Coalitions of America.

CALDATA – California Drug and Alcohol Treatment Assessment.

CAPTs – Centers for the Application of Prevention Technologies.

CARICOM – Caribbean Community.

CASA – Center on Addiction and Substance Abuse, a research organization based at Columbia University.

CBT – Cognitive-Behavioral Treatment.

CEWG — Community Epidemiology Work Group.

CDC – Centers for Disease Control and Prevention.

CICAD – Inter-American Drug Abuse Control Commission, a body of the Organization of American States.

CIP – Carrier Initiative Programs, an ongoing initiative of the U.S. Customs Service.

CNP – Colombian National Police.

CN-IWG – Counter-Narcotics Working Group.

COPS – Community Oriented Policing Services, a program of the Department of Justice.

CRA – Community Reinforcement Approach.

CSAP – Center for Substance Abuse Prevention, a component of SAMHSA, an operating division within the Department of Health and Human Services.

CSAT — Center for Substance Abuse Treatment, a component of SAMHSA an operating division within the Department of Health and Human Services.

CTAC – Counter Drug Technology Assessment Center.

CTN – National Drug Abuse Treatment Clinical Trials Network.

DAICC – Domestic Air Interdiction Coordination Center.

D.A.R.E. – Drug Abuse Resistance Education.

DATOS – Drug Abuse Treatment Outcome Study, run by the National Institute on Drug Abuse.

DAWN - Drug Abuse Warning Network, a SAMHSA-funded program which monitors drug abuse among persons admitted at hospital emergency rooms.

DEA - Drug Enforcement Administration, part of the Department of Justice.

DEFY - Drug Education for Youth.

DENS - Drug Evaluation Network SysteM.

DFS3 - Drug-Free Schools State Supplement.

DFWP - Drug Free Workplace Program.

DOD - U.S. Department of Defense.

DOJ - U.S. Department of Justice.

DOL - U.S. Department of Labor.

DOT - U.S. Department of Transportation.

DUF - Drug Use Forecasting program. Now known as ADAM.

EAP - Employee Assistance Program.

EPA - U.S. Environmental Protection Agency.

EU - European Union.

FAS - Fetal Alcohol Syndrome.

FATF - Financial Action Task Force, an international grouping of nations that fight money laundering.

FBI - Federal Bureau of Investigation, part of the Department of Justice.

FDA - Food and Drug Administration, part of the Department of Health and Human Services.

FDSS - Federal-Wide Drug Seizure System.

FINCEN - Financial Crimes Enforcement Network.

FY - Fiscal Year.

GAO - Government Accounting Office.

GBL — Gamma-Butyrolactone.

GCIP — General Counterdrug Intelligence Plan.

GHB - Gamma-Hydroxybutyrate.

G.R.E.A.T. - Gang Resistance Education and Training.

GTO - Geographic Targeting Order, a tool used to fight money laundering.

Hcl - Cocaine Hydrochloride.

HHS - U.S. Department of Health and Human Services.

HIDTA - High Intensity Drug Trafficking Area, a cou. terdrug initiative overseen by the Office of National Drug Control Policy.

HIV - Human Immunodeficiency Virus.

HLCG - U.S./Mexico High Level Contact Group on Drug Control.

HUD - U.S. Department of Housing and Urban Development.

ICRC — International Certification Reciprocity Consortium/Alcohol and Other Drugs.

IDU - Injection Drug User.

IEEPA - International Emergency Economic Powers Act, a law that deals with money laundering and the financial proceeds of drug trafficking.

ILEA - International Law Enforcement Academy.

INCASE — International Coalition of Addiction Studies Educators.

INCB — International Narcotics Control Board.

INCSR - International Narcotics Control Strategy Report.

INS - U.S. Immigration and Naturalization Service, part of the Department of Justice.

IOM - Institute of Medicine, part of the National Academy of Science.

ISIS/RVS - Integrated Surveillance Intelligence System and Remote Video Surveillance.

JIATF - Joint Interagency Task Force.

LAAM - Levo-Alph-Acetyl-Methadol.

LSD - Lysergic acid diethylamide, a hallucinogen.

MEM — Multilateral Evaluation Mechanism.

MET — Mobile Enforcement TeaM.

MDMA — 3,4-methylenedioxymethamphetamine, an illegally produced stimulant that has hallucinogenic properties.

MTF — Monitoring the Future, a long-term study of youth drug abuse and attitudes, run by the University of Michigan and funded by NIDA.

NAADAC — National Association of Alcoholism and Drug Abuse Counselors.

NASADAD — National Association of State Alcohol and Drug Abuse Directors.

NATA — Narcotic Addict Treatment Act.

NCHS — National Center for Health Statistics.

NDATUS — National Drug and Alcoholism Treatment Unit Survey.

NDIC — National Drug Intelligence Center.

NHSDA — National Household Survey of Drug Abuse, the most comprehensive of the many national surveys of drug abuse, funded by SAMHSA.

NHTSA — National Highway Traffic Safety Administration, part of the Department of Transportation.

NIAAA — National Institute on Alcohol Abuse and Alcoholism, one of the National Institutes of Health and part of the Department of Health and Human Services.

NICCP — National Interdiction Command and Control Plan.

NIDA — National Institute on Drug Abuse, one of the National Institutes of Health and part of the Department of Health and Human Services.

NIH — National Institutes of Health, part of the Department of Health and Human Services.

NIJ — National Institute of Justice, part of the Department of Justice.

NIMH — National Institute of Mental Health.

NMLS — National Money Laundering Strategy.

NNICC — National Narcotics Intelligence Consumers Committee.

NRC — U.S. Nuclear Regulatory Commission.

NTIES — National Treatment Improvement Evaluation Study.

NTOMS — National Treatment Outcome Monitoring System.

OAS — Organization of American States.

OCDETF — Organized Crime Drug Enforcement Task Force, a program of the Department of Justice.

OJJDP — Office of Juvenile Justice and Delinquency Prevention, part of the Department of Justice.

OJP — Office of Justice Programs, part of the Department of Justice.

OMB — Office of Management and Budget.

ONDCP — Office of National Drug Control Policy.

OPM — Office of Personnel Management.

PATS — Partnership Attitude Tracking Study.

PCP — Phencyclidine, a clandestinely manufactured hallucinogen.

PDFA — Partnership for a Drug-Free America, a private organization that promotes private-sector involvement in the creation of anti-drug messages.

PEPS — The Prevention Enhancement Protocols System developed by CSAP.

PME — Performance Measures of Effectiveness.

POE — Port of Entry.

PRIDE — Parent's Resource Institute for Drug Education.

PSA — Public Service Announcement.

RSAT — Residential Substance Abuse Treatment.

SAID — Substance Abuse Information Database.

SAMHSA — Substance Abuse and Mental Health Services Administration. An operating division within the Department of Health and Human Services.

SAPT — Substance Abuse Prevention and Treatment.

SBA — Small Business Administration.

SDFSCA — Safe and Drug Free Schools and Communities Act.

SDFSP – Safe and Drug-Free Schools and Communities Program.

SIDS – Sudden Infant Death Syndrome.

SIG – State Incentive Grant.

SIFCF – Survey of Inmates in Federal Correctional Facilities.

SISCF – Survey of Inmates in State Correction Facilities.

SMART – Self Management and Resistance Training.

SOD – Special Operations Division.

SROS – Services Research Outcomes Study.

STD – Sexually Transmitted Disease.

STRIDE – System To Retrieve Information from Drug Evidence, a program of the Drug Enforcement Administration.

SWB – Southwest Border.

TASC – Treatment Alternatives to Street Crime.

TCA – Therapeutic Communities of America.

THC – Tetrahydrocannabinol, the psychoactive substance in marijuana.

TIC – The Interdiction Committee.

TIPS – Treatment Improvement Protocols.

UCR – Uniform Crime Reports, a publication of the FBI.

UFDS – Uniform Facility Data Set, administered by SAMHSA.

UK – United Kingdom.

UN – United Nations.

UNGASS – UN General Assembly Special Session on Drugs.

UNDCP – United Nations International Drug Control Programme.

U.S. – United States.

USAID – U.S. Agency for International Development.

USCG – United States Coast Guard.

USCS – United States Customs Service.

USDA – Department of Agriculture.

USG – United States Government.

USIC – United States Interdiction Coordinator.

USMS — United States Marshals Service.

WtW – Welfare to Work.

XTC – A street name for MDMA.

YRBS – Youth Risk Behavior Survey.

⊙ TRUTH.

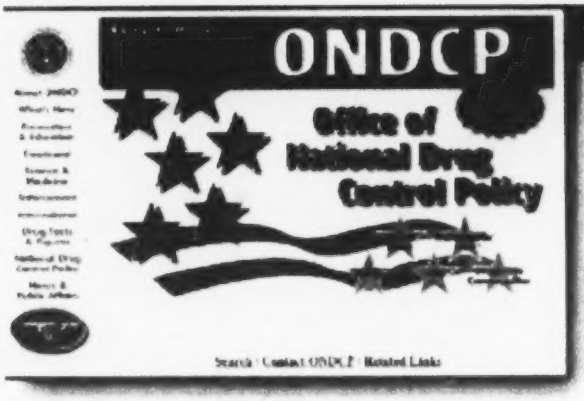
THE ANTI-DRUG.

The most effective deterrent to drug use among kids **isn't the police, or prisons, or politicians.** One of the most effective deterrents to drug use among kids is their parents. Kids who learn about the risks of drugs from their parents are **36% less likely to smoke marijuana** than kids who learn nothing from them. They are 50% less likely to use inhalants. 56% less likely to use cocaine. 65% less likely to use LSD. So if you're a parent, talk to your kids about drugs. Research also shows that 74% of all fourth graders **wish their parents would talk to them about drugs.** If you don't know what to say, visit www.theantidrug.com or call 800-788-2800. We can help you.

The Geocentric System

Five hundred years ago, the sun was thought to revolve around the earth. People did not know then what we know now. Truths change. We now know smoking marijuana is harmful. The younger you are, the more harmful it may be. Research has shown that people who smoke marijuana before the age of 15 were over 7 times more likely to use other drugs than people who have never smoked marijuana.

Illegal drugs are estimated to cost America over $110 billion each year in treatment, enforcement, incarceration and social damage. **But what else could you buy for $110 billion?** Well, you could build 1,692 new hospitals. Or operate 632 new universities. Or 3,667 national parks. You could hire 2,955,956 new high school teachers. Or you could put 758,620 new buses on the road. This message is brought to you by the Office of National Drug Control Policy/Partnership for a Drug-Free America℠

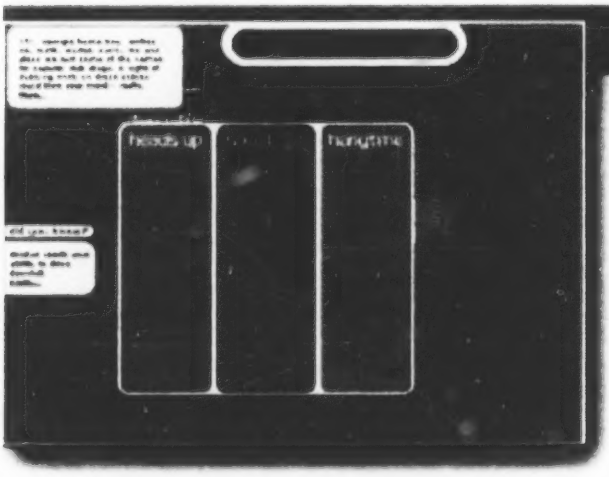


www.whitehousedrugpolicy.gov

- The President's drug policy
- Current data on drug use
- Prevention, treatment, and enforcement programs
- ONDCP initiatives, news, testimony
- Links to other valuable resources

www.theantidrug.com

- Provides parents and other adults strategies to help raise healthy, drug-free children.
- The site also encourages adoption of positive parenting practices through the main themes of love, trust, honesty and communication
- The site offers information in Spanish, Korean, Vietnamese, Chinese and Cambodian



www.freevibe.com

- Helps kids 10 - 15 understand the dangers of substance abuse and emphasizes the importance of making responsible decisions
- Site features moderated bulletin boards, role-playing games, media literacy tools and drug facts

National Drug Clearinghouse: 1-800-666-3332

Media Campaign Clearing House: 1-800-788-2800

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